

**HOMOSEXUALITY AND ITS RELATED HEALTH RISKS IN KILIFI TOWN
COUNCIL, KILIFI COUNTY, KENYA**

BY

EVAH MUMBI MAINA (BScN)

Q139/CE/21874/2012

**A THESIS SUBMITTED IN PARTIAL FULLFILMENT OF THE REQUIREMENTS
FOR THE AWARD OF A MASTERS DEGREE OF PUBLIC HEALTH,
REPRODUCTIVE HEALTH OPTION IN THE SCHOOL OF PUBLIC HEALTH,
KENYATTA UNIVERSITY**

DECLARATION

I hereby declare that this is my original work and has not been presented for a degree in any other university.

Signature_____

Date_____

Evah M Maina

Q139/CE/21874/2012

Department of Population and Reproductive Health

Supervisors

We confirm that the work reported in this thesis was carried out by the candidate and submitted with the approval of the University supervisors.

Signature_____

Date_____

Dr. Jackim Nyamari

Department of Environmental and Population Health

Kenyatta University

Signature_____

Date_____

Dr. Drusilla Makworo

Department of Community Health Nursing

Jomo Kenyatta University of Agriculture and Technology

DEDICATION

This study is dedicated to Nancy and Maureen, my dear mum and my lovely sister respectively.

ACKNOWLEDGMENT

I take this opportunity to appreciate everyone who has supported me and contributed to my writing of this thesis. Special thanks go to my supervisors Dr. Jackim Nyamari and Dr. Drusilla Makworo for their guidance, relentless advice and encouragement during this study. This study completion would not have been possible without your worthwhile inputs.

My sincere gratitude goes to my colleagues at Kirinyaga University College for their support and encouragement throughout this study. I am also grateful to the County Commissioner and the County Director of Health Kilifi County for granting me the permission to carry out the study in Kilifi County. Special thanks go to the Medical superintendent Kilifi County hospital, Officer Commanding Police Station Kilifi, County AIDs/STI control officer, MSM Kilifi representative, MSM friendly Nurse at KCH, Aphia plus MSM coordinator for their support in being resourceful Key Informants. My appreciation also goes to my research assistants and to all participants who took part in this study. This would not have been possible without your cooperation. May God bless you all.

TABLE OF CONTENTS

DECLARATION
DEDICATION	ii
ACKNOWLEDGMENT.....	iii
TABLE OF CONTENTS.....	iv
LIST OF TABLES	ix
LIST OF FIGURES	x
ABBREVIATIONS AND ACRONYMS	xi
OPERATIONAL DEFINITIONS.....	xii
ABSTRACT.....	xiii
CHAPTER ONE; INTRODUCTION	1
1.1 Background to the study	1
1.2 Problem Statement	4
1.3 Justification of the Study	5
1.4 Research Questions	5
1.5 Objectives of the Study	6
1.5.1 Broad Objective.....	6
1.5.2 Specific Objective	6
1.6 Significance and Anticipated Output	6
1.7 Limitation and Delimitation.....	6
1.8 Conceptual Framework.....	7
Figure 1.1 Conceptual Framework	7
CHAPTER TWO; LITERATURE REVIEW	9
2.1 Causes of Homosexuality	9

2.1.1 Theories on causes of Homosexuality.....	9
2.2 Biologic causes of Homosexuality.....	9
2.3 Environmental/ Child Upbringing causes of homosexuality	10
2.3.1 Feminization and Family Constellations.....	10
2.3.2 Distorted Female View When Growing Up.....	11
2.3.3 Gender Identity Problems.....	13
2.3.4 Bad Experiences with Men When Growing Up.....	13
2.3.5 Sexual Conditioning When Growing Up	14
2.4 Physical Factors	15
2.5 Cultural Factors in Development of Homosexuality	16
2.5.1 Urbanization.....	16
2.5.2 Education.....	16
2.6 Role of Personal Choice in Becoming Homosexual.....	17
2.7 Risky Sexual Behaviors among Men Who Have Sex With Men	18
2.7.1 Unprotected Anal Sex	18
2.7.2 Substance Abuse	18
2.8 Health Service Provision for MSM.....	20
CHAPTER THREE; RESEARCH METHODOLOGY	22
3.0 Introduction.....	22
3.1 Research Design and Rationale	22
3.2 Study Variables.....	23
3.2.1 Independent variables.....	23
3.2.2 Dependent variable.....	23
3.3 Location of the Study.....	23

3.4 Study Population.....	24
3.5 Sampling Techniques.....	24
3.6 Sample Size Determination.....	24
3.7 Pilot Study and Pretesting.....	25
3.8 Validity	25
3.9 Reliability.....	26
3.10 Data Collection Techniques.....	26
3.11 Data Analysis.....	26
3.11.1 Thematic content Analysis.....	27
3.12 Logistical and Ethical Considerations	28
3.12.1 Research Ethics Committee Approval	28
3.12.2 Consent for the Questionnaire, Focus Group Discussions and key informant interviews.....	28
3.12.3 Community considerations in the study.....	29
CHAPTER FOUR: RESULTS	30
PRESENTATION, ANALYSIS OF DATA AND INTERPRETATION OF FINDINGS....	30
4.0. Introduction.....	30
4.1. Questionnaire Response Return Rate.....	30
4.2 Demographic Information.....	30
4.3 predisposing factors to Homosexuality.....	32
4.3.1 Upbringing and Homosexuality	33
4.4 Role played by respondents in homosexual relationship.....	37
4.5 Respondents' awareness of their HIV status	37
4.6 Last HIV test.....	37
4.7 HIV testing with sexual partners together	38

4.8 Having more than one sexual partner concurrently over the last one year	39
4.10 Use of condom by the respondents	40
4.11 Reasons why there is no use of condoms all the time or sometimes	41
4.12 Use lubricants all the time when having sexual intercourse	42
4.13 Uses of alcohol and other drugs	42
4.14 Suffering from any disease	43
4.15 Existing Health Promotion and Management Services for Homosexuals	44
4.16 Disclosing sexual orientation to health service providers	45
4.17 Whether health service are friendly	46
4.18 Discrimination when seeking health care on HIV/AIDS and reproductive health	46
4.19 Accessing lubricant and condoms	47
4.20 Accessibility to prevention messages	48
4.21 Change of current sexual orientation	49
CHAPTER 5: DISCUSSION	52
5.0 Introduction	52
5.1 Causes of Homosexuality	52
5.2 Health Risks among Homosexuals	56
5.3 Existing Health Promotion and Management Services for Homosexuals	58
CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS	60
6.1 Conclusion	60
6.2 Recommendations	61
6.2.1 Recommendations to the Ministry of health	61
6.2.2 Recommendations to families and communities	62
6.3 Future Research	62

REFERENCES	63
APPENDICES	67
Appendix 1: Consent Form.....	67
Appendix 2: Questionnaire.	70
Appendix 3: Focused Discussion Consent Form.....	77
Appendix 4: Focused Group Discussion Guide.....	78
Appendix 5: Key informant interviews Consent Form.....	79
Appendix 6: Key Informant Interviews- CASCO	80
Appendix 7: Key Informant Interview- KDH Gay Friendly Nurse.....	81
Appendix 8: Key Informant Interview- MSM Representative	82
Appendix 9: Key Informant Interview- NGO Officer	83
Appendix 10: Key Informant Interview- Law Enforcer	84
Appendix 11: Map of Kilifi County.....	85
Appendix 12: Kenyatta University Ethics Committee Approval	86
Appendix 13: National commission for Science and Technology Approval	87
Appendix 14: County Commissioner Kilifi County Approval	88

LIST OF TABLES

Table 4. 1 Socio Demographic Information	31
Table 4.2 Predisposing factors to homosexuality	33
Table 4. 3 Upbringing and its influence on homosexuality	36
Table 4. 4 Role played by respondents in a homosexual relationship	37
Table 4. 5 Knowledge of respondents HIV status	37
Table 4. 6 Testing of HIV with sexual partner.	38
Table 4. 7 More than one sexual partner concurrently over the last one year	39
Table 4. 8 Condom use by respondents	41
Table 4. 9 Reasons why respondents don't use condom all the time	42
Table 4. 10 Use of lubricants	42
Table 4. 11 Diseases respondents have suffered from	44
Table 4. 12 Disclosing sexual orientation to health service providers	46
Table 4. 13 Provision of gay friendly services	46
Table 4. 14 Discrimination when seeking health services	47
Table 4. 15 Accessibility to condoms and lubricants	48
Table 4. 16 change of current sexual orientation	49
Table 4.17 F test.....	50

LIST OF FIGURES

Figure 1. 1 Conceptual Framework	7
Figure 4. 1 When last HIV test was done	38
Figure 4. 2 Number of sexual partners.....	40
Figure 4.3 Use of alcohol and drugs	43
Figure 4. 4 Access to health services	45
Figure 4. 5 Access to prevention messages	49

ABBREVIATIONS AND ACRONYMS

AIDS - Acquired Human Immune Deficiency Syndrome

CDC - Centers for Disease Control and Prevention

CASCO- County Aids and STI Control Officer

DHIS- District Health Information System

HIV - Human Immunodeficiency Virus

IDU - Intravenous Drug Users

KAIS - Kenya AIDS Indicator Survey

KDH- Kilifi District Hospital

MSM - Men who have Sex with Men

NGO- Non Governmental Organization

OCS- Officer Commanding Station

STI- Sexually Transmitted Infections

OPERATIONAL DEFINITIONS

Bisexuality - Sexual behavior, sexual attraction and sexual orientation towards both females and males.

Gay – These are homosexual males.

Heterosexuality – Sexual behavior, romantic sexual attraction and sexual orientation between people of opposite sex or gender.

Heterosexism – These are attitudes, bias and discrimination in favor of opposite sex relationships and sexuality and viewing heterosexuals as the only norm.

Homosexuality - Romantic sexual attraction, sexual behavior and sexual orientation between people of the same sex. In this study, the word homosexual has been used to describe men who have sex with men.

Homophobia – These are a range of negative attitudes and feelings towards homosexuality expressed as contempt, hatred or prejudice and are sometimes related to religious beliefs.

Kings- Male MSM who are the inserters and are “men” during sexual intercourse.

Lesbians – They are homosexual females.

Queens – Male MSM who are the recipients and are “women” during the sexual intercourse

Transgender- This is the state of a person’s gender identity, it relates to the status of a person whose self-identity does not conform unambiguously to the convention notions of male or female. It is appearing as, wishing to be considered or having undergone surgery to become a member of the opposite

ABSTRACT

HIV/AIDS was originally referred to as “gay disease” because high numbers of initial patients were homosexuals. Understanding causes of homosexuality and related health risks is important in formulating MSM targeted behavioral interventions towards positive health outcomes. Men who have sex with men are in this category of key populations according to World Health Organization. This study’s main objective was to determine predisposing factors to homosexuality and its related health risks in Kilifi town council. Specific objectives were: to determine factors predisposing men to homosexuality, determine health risks among homosexuals and to establish health promotion and management services for MSM in Kilifi town council. This study used a descriptive cross-sectional design and snowballing sampling was used to reach MSM. The study population included MSM in Kilifi town council, both self-identified and non-self-identified. Data collection methods included self-administered questionnaires with MSM, 2 focused group discussions each with 12 participants and key informant interviews. The key informants were drawn from health care institutions providing MSM friendly services both in the private and the public health sector, and law enforcement agencies that ensure the safety of MSM in the community, CASCO, MSM representative and an NGO officer. Quantitative data analysis was conducted using IBMSPSS[®] 21.0. Chi-square values and cross tabulation were used to test the significance of the association between the dependent and independent variables. Qualitative data from FGDs and key informant interviews were transcribed and analyzed by thematic content analysis technique. Overall, 72 MSM aged between 18.0 to 58.0 years (mean age: 24. ±0.676 years) took part in the study. This study showed that homosexuality is as a result of socialization rather than biological causes. Majority of respondents (66.7%) cited choice as the reason they are homosexuals. Majority (88.9) cited homosexuality as a lifestyle, meaning it’s a decision they made. Peer pressure was the leading cause of homosexuality (58.3%), with friends (69.4%) being the primary people who introduced most homosexuals to the behavior. Watching pornography (69.4%) when growing up was a predisposing factor to homosexuality. Non condom use at 69.4%, multiple sexual partners (83.3%), drug abuse (91.7%), and discrimination (63.9%) are some of the health risks the homosexuals had. Health services were somewhat gay friendly (55.6%). Majority (80%) access health services from government facilities. In Chi-Square statistic, type of family setup is related to respondents watching pornography while growing up ($p < 0.05$). This study recommends policy formulation to enhance gay friendly comprehensive health service provision, MSM sexual reproductive health education and community and parental involvement to reduce number of boys who convert to homosexuality at some point in life.

CHAPTER ONE; INTRODUCTION

1.1 Background to the study

Men who have sex with men are often classified under homosexuals. Homosexuality is the term used to refer to people who are romantically attracted, sexual attraction or sexual behavior between members of the same sex (Milton, 2011). Homosexuality also refers to the individual sense of personal and social identity based on these attractions, behaviors that express them and membership to a community of individuals that share the beliefs and sexual orientations (James, 2006). Along with heterosexuality, bisexuality and homosexuality these three make the main categories of sexual orientation within the continuum of heterosexual - homosexual. Scientists have no consensus as to why people develop certain sexual orientations but biological based theories have been favored by experts who relate this to genetic predisposition and early uterine development (Milton, 2010). The common terms for homosexuals are Lesbian for females who have sex with females and gay for men who have sex with men. Many men who have sex with men are in committed same sex relationships with few being bisexual. The number of people who identify themselves as homosexuals is difficult to determine since not many declare this openly, especially in the African set up due to homophobia and heterosexist discrimination (Milton, 2010).

According to Bily (2009), Men who have sex with men (MSM) was a term coined in 1992 in an attempt to capture a range of male- male sexual behaviors and avoid characterization of men engaging in these behaviors by sexual orientation (homosexual, heterosexual, bisexual or gay) or gender identity (male, female, transgender, queer). MSM includes gay- identified men, heterosexually identified men who have sex with men, bisexual men, male sex workers who can

have any orientation and men engaging in these behaviors in all male settings like prison. Transgender people born male share some biological risks with MSM, especially receptive anal intercourse, but their female gender identity places them in a different category from MSM; hence not included as subgroup in MSM (Bily, 2009).

Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) was originally referred to as “gay disease” due to the high numbers of patients who presented with the disease that were homosexuals. Men who have sex with men are classified under the key populations (Ferrebe, 2012). Understanding the sexual behaviors of populations who are vulnerable to HIV is an important component in the fight against HIV/AIDS. In Kenya, male homosexuality is criminalized under the penal code and there is wide spread stigma and discrimination against homosexuals. This environment has made it difficult for these people to access health services thereby increasing their vulnerability to negative health outcomes including HIV/AIDS, STI’s and other health consequences. The Kenya National Aids and STI program has reported prevalence of HIV to be 18.2 among MSM in Nairobi and 11.1 percent among MSM in Kisumu. The Kenya modes of transmission study (2008) had previously estimated that nationally, 15 percent of new infections occur among MSM and prison populations. Although homosexuality is illegal, HIV pandemic among MSM has started being addressed by government institutions.

In September 2010, Reuters reported that nearly one in five gay and bisexual men in twenty one major U.S cities were infected with HIV and nearly half of them did not know it (Milton 2010). According to Centers for Disease Control and Prevention (CDC, 2010), men who have sex with men represent approximately 2 percent of the U.S population and are yet the population most

severely affected by HIV and the only risk group with steadily increasing infections since 1990s. In 2006, MSM accounted for 53 percent of new HIV infections in the United States. According to UNAIDS (2010), the prevalence of HIV/AIDS in MSM in sub-Saharan Africa was 17.9 percent, middle east 3.0 percent, east Asia 5.2 percent, north America 15.4 percent and Central and South America 14.9 percent. In Kenya the incidence of HIV among MSM is as high as 35 percent compared to 6 percent in heterosexual men. Prevalence of HIV among MSM equals or exceeds that seen in the general population in most sub-Saharan countries (Maulsby, 2012).

According to Bowers, Branson, Fletcher & Reback (2012), the medical dangers of homosexuality are under emphasized. Homosexuality is associated with higher rates of sexually transmitted diseases, substance abuse and mental illnesses. While in U.S homosexual men represent about 2 percent of the population, they represent the population with the highest burden of hepatitis B infection and around about 44 percent of new HIV infections annually. Homosexuality is also associated with high mortality rates. A major Canadian medical Centre found out that life expectancy at age of 20 years for gay and bisexual men was 8 to 20 years less than that for all men. It further estimated that nearly half of today's gay and bisexual men 20 years old would not reach their 65th birthday (Bowers et al, 2012).

Homosexuality has been linked to many causal factors; this study will focus on examining some of these predisposing factors. A common argument is of the inclination that homosexuality is genetic, inborn and immutable. It is however disregarded on the fact that public is likely to become more accepting of homosexuality if they are convinced it is inborn. Religious beliefs have been associated with homosexuality with fewer orthodox Jews being homosexuals and

many atheists practicing homosexual. Other associated factors are culture, sexual abuse and simply as a choice (Association of Nurses, 2003).

This study will explore the predisposing factors to homosexuality, its related health risk factors and health services availability and utilization by homosexuals, in an attempt to provide practical solutions.

1.2 Problem Statement

Research in many African countries indicates higher HIV prevalence among men who have sex with men and higher incidence rates from male to male sexual activity compared to the general population (Maulsby, 2012). Furthermore, consistently higher levels of infection among men who have sex with men and formidable cultural, social and legal barriers, combined with high levels of stigma and discrimination, have inhibited the provision of MSM-targeted health promotion and management services. Homosexuals contract syphilis at a rate 3-4 times higher than heterosexual men. Anal intercourse causes hemorrhoids, anal rectal trauma, anal fissures, retained foreign bodies and high risk for anal rectal cancer. According to Kenya AIDS Demographic Survey (KAIS, 2012) HIV incidence among MSM in Kenya is at 35 percent. Kilifi County has 300 identified MSM (DHIS, 2014). Behavioral interventions such as understanding the causes of homosexuality are not widely researched in Kenya and causes of homosexuality are important to understand in formulating behavioral interventions.

From 2002 to 2003, however, formative and qualitative assessments in both Nairobi and Mombasa strongly suggested that MSM existed in larger numbers than was commonly perceived in Kenya. However, no survey or quantitative data or causes of MSM had ever been gathered prior to 2004 (Sharma & Bukasi, 2008). It's against this background that this study aims to fill this knowledge gap on causes of homosexuality. This study choose Kilifi MSM as a

subgroup of coastal MSM population. Furthermore, the existing literature suggests lack of socio-behavioral studies, lack of intervention studies specifically targeting MSM, and lack of studies in smaller cities, towns and rural areas. This study therefore is an attempt to gain an in depth understanding of predisposing factors and health risk behaviors in MSM in an attempt to reduce health consequences among this population. Despite increasing evidence that homosexuals are disproportionately affected by HIV/AIDS, STI and other health conditions, in Africa there is still poor targeting within national strategic AIDS plans and through programs and services. Discrimination and illegality of homosexuality that calls for maximum of fourteen years in prison has made it difficult for MSM to access health care in health institutions which predispose them to more negative health outcomes. This study aims at reducing these gaps in Health risks faced by homosexuals, establishing causes of homosexuality and improve their overall health outcome.

1.3 Justification of the Study

MSM are disproportionately affected by HIV, STI's and other health risks and account for almost half of all new HIV infections diagnosed in Kenya. Coastal Kenya is one of the regions with the highest population of MSM. There is need to understand the predisposing factors to homosexuality to enable formulation of MSM targeted prevention strategies. Deep insight into the health risks by MSM will enable filling gaps in health care that limit accessibility to reproductive health services by MSM. Policy makers and stakeholders need sensitization that all people regardless of their sexual preferences are able to access the prevention, care and treatment services they need.

1.4 Research Questions

1. What are the factors that predispose men to homosexuality in Kilifi town council?

2. What are the health risks among homosexuals in Kilifi town council?
3. What are the existing health promotion and management services for homosexuals in Kilifi town council?

1.5 Objectives of the Study

1.5.1 Broad Objective

To determine predisposing factors to homosexuality and its related health risks in Kilifi town council, Kilifi County.

1.5.2 Specific Objective

1. To determine factors predisposing men to homosexuality in Kilifi Town council.
2. To determine health risks among homosexuals in Kilifi Town council.
3. To establish the existing health promotion and management services for homosexuals in Kilifi Town council.

1.6 Significance and Anticipated Output

The purpose of this study is to get an insightful understanding into the physical, social, emotional and biological factors that predispose men to homosexuality as well as health risk factors that expose them to more negative health outcomes. This will help the study come up with more targeted approach to reducing the burden of negative health outcomes in this population.

1.7 Limitation and Delimitation

MSM are composed of those married to women, difficult to reach for surveillance and less willing to disclose sexual practices than gay self-identified men, challenging responses in this study. This is true in set ups like Kenya, where same sex behavior is stigmatized and criminalized. This study will therefore use snowballing sampling technique that will allow access to this population while maintaining confidentiality.

1.8 Conceptual Framework

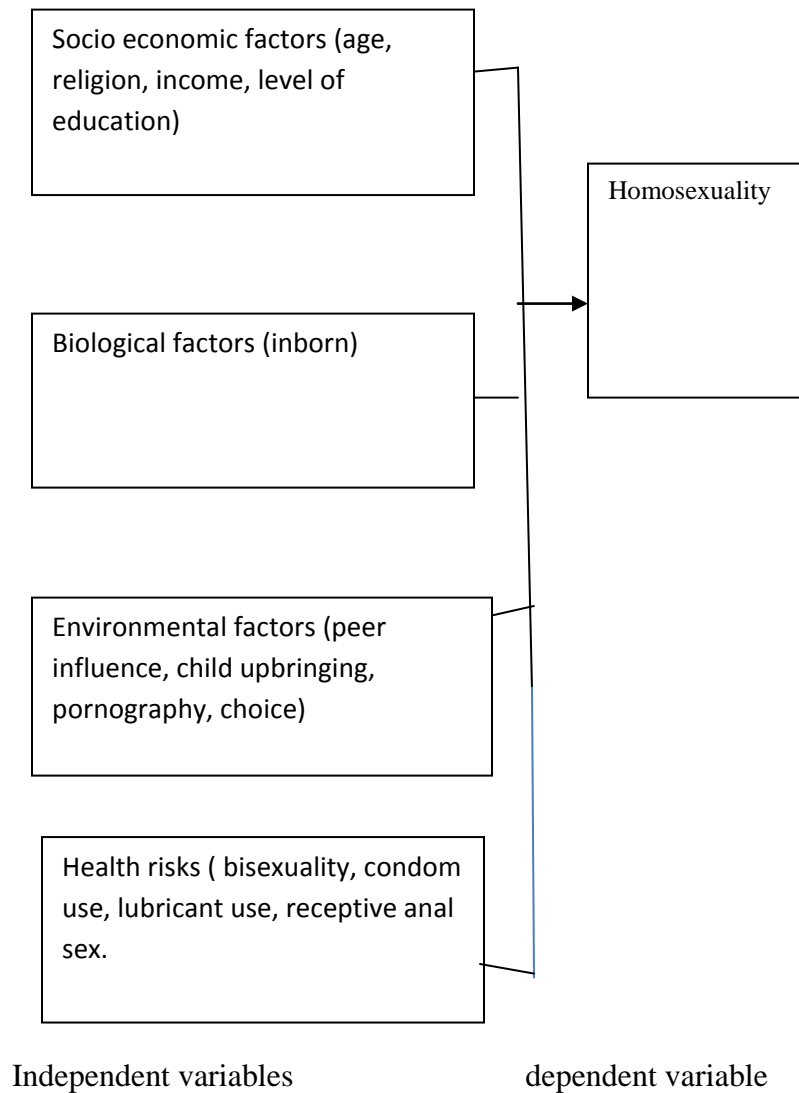


Figure 1. 1Conceptual Framework

The study seeks to establish factors predisposing one to homosexuality, these factors include; socio-economic factors (age, income, religion and level of education), biological factors which are mainly inborn and environmental factors (peer influence, child upbringing, pornography and

choice) have any role in one becoming a homosexual. The study will also establish how health risk behaviors like bisexual sex orientation, drug abuse, receptive anal sex, condom use and use of lubrication impact their health.

CHAPTER TWO; LITERATURE REVIEW

This chapter covers the predisposing factors to men having sex with men that range from biological, social and environmental issues. It also reviews literature on risky sexual behaviors.

2.1 Causes of Homosexuality

According to Bily (2009), same sex attraction in males and behaviors can be attributed to a number of emotional, psychological, social and biological factors. These attractions can be traced way back in a boy child history of upbringing.

2.1.1 Theories on causes of Homosexuality

There are two main theories explaining homosexuality. One is that homosexuality is caused by genetic or biological factors which mean people are born gay. The second theory is that homosexual orientation develops as a result of psychological and environmental influences and experiences when the boy is growing up. In the public domain the latter theory has lost popularity with scientific research unable to conclude this evidently and the former is gaining favor in recent decades (Ferrebe, 2012).

2.2 Biologic causes of Homosexuality

According to Ferrebe (2012), brain studies, prenatal hormone levels studies and twin studies have over the years failed to conclusively link genetic factors as the cause for homosexuality sex orientation. This theory of genetic causes as to the reason why people become homosexuals has failed to be proven by scientists and therefore has no credibility. Twin studies also showed that genetic twins were not necessarily of the same sexual orientation. Research linking homosexuality to genetic and biological causes has been inconclusive. But there is evidence that suggests that biological factors can have indirect impact by affecting some parts of developmental pathway. Research has been done in an attempt to link homosexuality to various

genetic, hormonal and neurological factors but it has failed to produce concrete evidence about the causes of homosexuality (Milton, 2010).

2.3 Environmental/ Child Upbringing causes of homosexuality

Many upbringing and environmental factors have been associated with men being homosexuals. Unhealthy boy child relationships with females are one of the causes of homosexuality. Females who include mothers, sisters and the extended female family members, teachers, baby sitters and others can wound a boy when he is growing up in a variety of ways. Females often overwhelm the growing boy with too much smothering attention and love (James, 2006). They may overprotect him, leaving him feeling incapable and emasculated. The boy may grow up being criticized by females for his weaknesses, causing lasting feelings of shame, self doubt and insecurity.

2.3.1 Feminization and Family Constellations

Sometimes the boy may be feminized by females by being dressed as a girl or even telling him he is a girl. When females fail to observe the boundaries and standards of modesty, they may sexualize the relationship with a boy. This is often done by leaving bathroom and bedroom doors open while they are changing clothes, walking around the house naked or in just an inner wear and using the toilet while its open. Females may also directly abuse the boys by engaging them in sexual behavior occasionally or they may sexualize him by making comments about his body or talking to him about their sex lives (Bily, 2009).

According to Byne and Parsons (2005), many and perhaps of majority homosexual men report family constellations to be casually associated with development of homosexuality, for example (overly involved, anxiously over controlling mothers and poor father – son relationships. This association has been observed in both clinical and non clinical samples.

This kind of experiences makes the boy develop unhealthy relationships with females during adulthood. Some same sex attracted individuals have related to women with feelings, impulses and behaviors from more than one of these categories. Those who become oppositional in their relationships tend to push women away or reject them. They have feelings of dislike, resentment, disgust or even hatred towards women. Some MSM are completely conscious and blatant about their dislike for females. Men who develop avoidance in their relationships with women experience feelings of fear and anxiety which make them keep distance from women (James, 2006). Others feel indifferent and apathetic towards women and can treat them as if they do not exist. The distancing and oppositional ways of relating with women often block adult's male natural attraction to women. Those who become enmeshed with women tend to seek their approval or become dependent on their support. They may allow themselves to be controlled by women, becoming their subordinates (Milton, 2010).

The same sex attraction males who develop good relationship with women tend to seek out females settings as safety sources, security and consolation. They are more than at ease with women, showing an over- familiarity and over-resonance with women, sharing their interests and perspectives or having a feeling of being included as "one of the girls". These comfortable and enmeshed relationships with women are ways of clinging too closely to feminine. When a man is feminized by women and girls when growing up, it brings the feeling of feminine even more closer in adulthood (Locke, 2005).

2.3.2 Distorted Female View When Growing Up

The male childhood experiences play a great role in distorting boys concepts of gender (James, 2006). Unhealthy childhood experiences with females can cause a man's concept of gender to become distorted. Many MSM develop views about women that are not accurate as a whole.

They may view women as controlling, demeaning, emasculating, powerful, dominating and shaming. On the other hand though, men attracted to men sexually may view women as more intelligent than men, pure or sacred and unrealistically pure. They prefer women's roles and lives because they are easier and better suited for their own personality. They may look at women as providers and protectors (Association of nurses, 2003).

According to Bowers *et al* (2012), unhealthy childhood experiences with females may make the man have self-distorted concepts on his relation to women. A male attracted sexually to other males may view himself as needy and weak in comparison with women, undesirable or inferior to women. The man may feel incapable of handling demands of an intimate relationship with a woman. Women were the main source of role modeling when these men are growing up and the men in their lives may have had very little or no impact. Men who grow up in such settings become identified with women often, experiencing them as familiar and resonant. Over familiarity and identification with females greatly impact a growing boy's sense of genderedness. Genderedness is the state of having two sexes that are naturally distinct. To develop a healthy sense of genderedness, a boy must experience and view himself as masculine in contrast with femininity of women. Being identified with females and over familiarity with them washes out this contrast in a boy (James, 2006).

Distorted views of female gender and a boy's distorted perceptions of himself in relation to females can prevent a boy developing a sense that girls are contemporary to his maleness. He becomes unable to recognize the favorable relationship that can develop with opposite sex members as a natural trait. Most homosexual men have reported that during childhood, they saw themselves as being odds or out of sync with what a boy is supposed to be. They had a perspective of being different from other boys. This condition is known as "gender incongruity",

the boys experience a sense of lack of vital qualities they consider essential to masculinity (Ferrebe, 2012).

2.3.3 Gender Identity Problems

According to Friedman (2008), a history of gender identity pathology including chronic unmasculinity and effeminacy is common among men who are predominantly or exclusive homosexuals than men that are exclusively heterosexual.

According to Bailey (2005) “Most sissies will grow up to be homosexuals and most gay men were sissies as children”...”Despite the provocative and politically incorrect nature of this statement, it fits the evidence. In fact it may be the most consistent well documented and significant finding in the field of sexual orientation research and perhaps in all human psychology”

According to Bem (2000), the most common reasons given by gay men and lesbians for having felt different from same-sex peers in childhood were atypical preferences and behaviors in childhood of gender non conformity. Childhood gender conformity or non conformity was the only strongest and significant childhood predictor of later sexual orientation for both men and women. Problems in relationships with other males when growing up have been linked to homosexuality. During childhood, some boys disconnect from other males due to negative stereotypes about males, fear of being seen as strange and negative experiences with males. This therefore leaves boys normal needs for same sex connection unmet, resulting in longings and cravings for male closeness.

2.3.4 Bad Experiences with Men When Growing Up

Painful or alienating experiences with father, brother, peers and other males can lead a boy to pulling away from males and creating a sense of same sex disaffiliation. They may be caused by

abuse, harassment, rejection and non-inclusion by males the boy grows around. These experiences may cause unhealthy relationships with males in adulthood; they could be oppositional, detached, inauthentic or needy (Bem, 2000). Those who become oppositional respond to other males with rejection anger or disgust. Boys who become detached respond to other males by disinterest and distancing themselves. Boys who develop inauthentic relationships tend to be anxious and superficial with other males. Boys who develop needy relationships with males long for male intimacy, long to be taken care of by males and they become dependent of male attention, affection and approval (Bem, 2000).

2.3.5 Sexual Conditioning When Growing Up

Sexual conditioning when growing up can predispose one to homosexuality. Humans can become conditioned in their behavior, often by creating strong associations between different stimuli. It is possible to become conditioned to respond sexually to others of the same sex. This can occur in three ways: through childhood sex play, through sexual abuse and through pornography (Bem, 2000). During male to male sexual abuse, boys are exposed to male stimuli simultaneously and sexual stimulation. During sexual play with other boys or females, male stimuli and sexual stimulation are paired. Pornography featuring men or boys places males in a sexual context (James, 2006). In the highly sexualized context of pornography, boys may confuse feelings of curiosity, envy, awe and wonder with sexual arousal. Once learned, pleasurable sexual behaviors are reinforced and boys continue engaging in them. When a boy becomes sexually aroused by male images out of sexual exposure, it may cause him to believe or confirm to him that he is homosexual or gay. This then becomes learned part of his identity (Bailey, 2005).

2.4 Physical Factors

Genetic and physical traits that cause boys to feel different from other boys or be singled out from their peers can interfere in their future relationships with men. This can also cause the boy feel incongruent with what he is supposed to be (Ferebbe, 2012). These physical and biological conditions makes the boy to be singled out in negative ways, they include: having physical deformity, being over or under weight, having high or low intelligence, concerns about penis size or being uncircumcised, having unusual appearance- attractive or non-attractive, experiencing puberty earlier or later than peers. Medical conditions and physical traits that interfere with gender- typical activities like athletics can interfere with same sex affiliation and gender congruity. They include: having an atypical body size, having poor body coordination, experiencing illness and debilitating disease, physical disabilities and lack of strength and endurance (Ferebbe, 2012).

Some theorists suggest that biology influences children's temperaments and their preference of sex atypical activities and peers leading them to feel different from others of their sex. They later become attracted to what they are different from (Bem, 2000). "(Exotic becomes erotic theory) proposes that biological variables such as genes, prenatal hormones and brain neuroanatomy, do not code for sexual orientation as per se but for childhood temperaments that influence child's perspectives for sex atypical or sex atypical activities and peers. These preferences make children feel different from peers of opposite or same sex and perceive them as dissimilar, unfamiliar and exotic. This then produces a heightened non specific autonomic arousal that subsequently gets eroticized to that same class of dissimilar peers: Exotic becomes erotic"

2.5 Cultural Factors in Development of Homosexuality

Two factors strongly stand out as having strong correlation with greater likelihood of engaging in homosexuality or self identifying as a homosexual: urbanization and education (Robert, John, Edward & Gin, 2004).

2.5.1 Urbanization

According to Robert, John, Edward and Gin (2004), Homosexual males tend to be concentrated in the urban areas. In America, more than 9 percent in nation's twelve largest cities identify themselves as gay. Only 1 percent of men in rural areas identify themselves as gay. This demography study revealed high levels of urbanization among homosexuals. Gay men are concentrated in certain urban areas. The explanation to this kind of phenomenon is that gay men are born evenly spread across a country but tend to navigate towards adulthood to big cities where they can feel accepted and find a substantial community of other homosexuals. The other explanation however is that, people who are born in large cities are more likely to be homosexuals than people born in suburbs, towns and country side. Robert et al (2005) directly contradict the notion that people are born gay by their hypothesis on why urban upbringing is correlated with homosexuality.

2.5.2 Education

As the case with urbanization, high levels of education are directly correlated with homosexuality behavior and self identification as gay. According to a study in the journal of science, by Robert, Charles, Albert and John (2009), men with four or more years of college are estimated to have high proportion with same gender sexual attraction and experience compared to those with no college education.

The interpretation is that higher levels of education are associated with greater sexual and social liberalism and with greater sexual experimentation. Robert et al conclude that acceptance of non traditional sexual behavior is likely to be higher among the more educated male homosexuals.

2.6 Role of Personal Choice in Becoming Homosexual.

Most debates over causes of homosexuality are often presented in terms of false dichotomy, either a person is born gay or a person chooses to be gay. The truth lies between these two extremes. For the most part, people do not choose what sexual feelings or attractions they experience. Each of us however, does choose which sexual behavior to engage in. According to Bayne and Parsons (2005), the role that “choice” plays in development of one’s sexual orientation is an active role of the individual in constructing his or her identity. The writers further explain that this is not meant to imply that one consciously decides one’s sexual orientation. Instead, sexual orientation is assumed to be shaped and reshaped by a cascade of choices made in context of changing circumstances in one’s life and enormous social and cultural pressures.

While nature and environment can make one more predisposed to homosexuality, secular studies have also indicated that most homosexuals have been attracted to members of opposite sex at one time. A research done by Robert Goetz (2004) identified articles and books that contained some relevance to the possibility of sexual orientation change. Of the data reported in that study, 31 of the 84 studies showed a quantitative outcome of individuals able to change sexual orientation. This means that individuals who chose to be homosexuals can reverse this behavior with therapy. Most homosexuals refer to homosexuality as a lifestyle. This indicates that homosexuality is a choice. Making a choice is a decision in the mind that too often originates in the heart from feelings. However, laws and moral standards are not set in place based on feeling or emotions.

2.7 Risky Sexual Behaviors among Men Who Have Sex With Men

Men who have sex with men are faced with an increased risk of contracting HIV relative to their exclusively heterosexual peers (Association of Nurses, 2003).

2.7.1 Unprotected Anal Sex

No sexual behavior is more risky than unprotected anal sex, and evidence indicates that percentages of MSM who engage in this behavior remain high. Because of the high risk of contracting HIV, documenting factors associated with unprotected anal intercourse among MSM is important to efficacious education and HIV prevention programming (Valle, Evangelista, Valesco, Kribs and Schmitz (2004).

According to Valle *et al* (2004), MSM report an earlier age of sexual debut and about 1.3 times the number of sexual partners. In other words, MSM compared to their exclusively heterosexual partners have more opportunities to engage in risky sexual behaviors due to their greater number of sexual partners. These study findings were consistent with problem behavior theory's assumption that a specific risk behavior is more likely to the extent that it is part of "constellation" of problem behaviors. Recent findings from qualitative interviews with MSM show that having a steady dating partner may paradoxically increase risk of contracting HIV by reducing condom use with the steady partner in a demonstration of intimacy and trust (Adam. Sears and McMillan, 2002). Individuals who for go using condoms in a sexually exclusive relationship, however still face the risk of disease transmission to the extent that "exclusive" partners also have sex outside their primary relationship. MSM who use substances are more likely to engage in sexual risk behavior and are more likely to be HIV positive or test positive for sexually transmitted infection.

2.7.2 Substance Abuse

Previous studies have shown that MSM engage in concomitant risk behaviors that increase HIV risk. MSM have reported twice as frequent use of drugs and alcohol before sex than their exclusively heterosexual peers (Wheeler, 2005). Steuve, O'Donnell, Duran, Doval and Geier (2002), in a study conducted in over 3,000 MSM discovered that nearly one third of their sample "reported being high on drugs or alcohol the last time they had sex with a non main partner, and men who were high were over 60 percent likely to have engaged in unprotected receptive anal intercourse. Substance abuse was associated with other factors, including having multiple sexual partners, trading sex and succumbing to peer norms discouraging condom use that increase risk of MSM contracting HIV.

Situational evidence demonstrates that concurrency of sexual behavior and substance use predicts risky sexual behavior. The mechanisms under which this association occurs is however not entirely clear. Some studies suggest that personality factors, namely sensation seeking, may explain the relationship between substance abuse and sexual risk behavior, longitudinal research shows that MSM engage more in risky sex during periods of heavy substance use compared to periods of lighter substance use and abstinence (Wheeler, 2005). Despite the evidence for casual link, there are MSM who engage in sexual risk behavior without being under influence of substances and there are MSM who engage in substance use but do not engage in sexual risk behavior.

Men who have sex with men could have multiple same sex partners while others are married to members of the opposite sex who have no idea of their homosexual orientation. They marry to fit in the societal expectations and lead double lives with more than one sexual partner which increases the risk for non condom use. Some gay men are exclusively homosexuals while others are bisexual (Maulsby, 2012). This is a sexual risk behavior exposing them to HIV infection.

2.8 Health Service Provision for MSM

Homophobia remains the overarching challenge of men who have sex with men. In the African set up, homophobia is more than in the western countries. The stigma and discrimination experienced in homophobic society places MSM at increased risk for physical and emotional damage and reduce the ability of these men to gather access resources or speak publicly (Maulsby 2012). This discrimination and homophobic culture have hindered MSM from accessing medical services hence exposing them to more danger of HIV infection and other STIs. They are afraid to seek out sexual and reproductive health information from health facilities due to fear of disclosure and the likely consequences. The most stigmatized group of MSM is particularly those who have sex with men for commercial reasons (Wheeler, 2005).

Kenya National Commission on Human Rights (2012) reported that homosexuals are discriminated, stigmatized and subjected to violence because of their sexual orientation. In cases where they need medical care, they suffer stigma which is perpetuated by health care providers who breach their privacy and confidentiality by exposing their sexual orientation to other colleagues at the facilities. The health care providers are not friendly and hardly understand their sexual and reproductive health needs. Health care workers have also not been adequately trained on provision of Gay friendly services, examination of sexual anal diseases, assessment and management of these conditions. In Kenya homosexuals have been profiled as drug users, past prison convicts or individuals with crime track record. The illegality and stigma associated with homosexuality create a situation for people to harass, extort and threaten to reveal homosexual sexual orientation to community. Most homosexuals who have come out openly to self identify themselves as gay have faced rejection and even loss of employment. Those who stay closeted

live two lives simultaneously. Many MSM are therefore afraid to seek health care or to be truthful to service providers because they think they will be preached down.

Although MSM have the highest risk of HIV transmission, outreach to them by health care providers lacks. They also lack access to comprehensive sex education that could improve the quality of their lives. Most MSM lie to health care providers because they are uncomfortable of discussing their sexual practices openly (Wheeler, 2005). According to Association of Nurses (2003), homosexual centered or gay friendly health services and counseling can make MSM comfortable talking to health care provider since it is clear that the counselor will understand their needs without judging them. Beyond the struggles with health care, MSM face daily challenges in patriarchal traditional society of Kenya.

CHAPTER THREE; RESEARCH METHODOLOGY

3.0 Introduction

This chapter highlights the research design that was used to answer the research questions as precisely as possible. The section further outlines the target population and the sampling technique that was used to obtain the desired sample size. Sampling frame that outlined proportion of the population that was used is part of the chapter. This was followed by the data collection procedure and an in depth explanation of data screening and cleaning process to correct errors. A methodical data analysis plan was delineated showing how the researcher analyzed the data to obtain answers to the research questions. The researcher identified and brought to light the threats to validity that the findings of the study had which included internal and external threats. The chapter concludes by highlighting the ethical issues that the researcher considered in the study.

3.1 Research Design and Rationale

In line with the study objectives homosexuality was the dependent variable while biological factors, socio- economic factors (income, age, level of education, religion) and environmental factors were the independent variables. When choosing a research design, Creswell (2003) observes that a researcher should utilize a design that enables collection of data and its analysis to give results to answer the research questions unambiguously. The framing of the research questions and the expected relationship between the study variables affects choice of research design (Johnson & Christensen, 2008). With these considerations in mind, a descriptive cross-sectional study design was used in this study. This is because the study involved studying the subjects descriptively at a point in time.

3.2 Study Variables

3.2.1 Independent variables

- a) Socio economic factors
- b) Biological factors
- c) Environmental factors
- d) Health risks

3.2.2 Dependent variable

Homosexuality

3.3 Location of the Study

The study was carried out in Kilifi town council area of the Kilifi County. Located about 60km north of Mombasa, Kilifi town is the main stop on the Mombasa-Malindi highway. The town is set on Kilifi Creek between Mombasa and Malindi, which is about 52km away. Kilifi is reknown for its tourist attractions such as Bofa Beach - located 2.5km from the town, Mnarani Ruins and the Vasco da Gama Pillar. The town is home to many resorts including Kilifi Bay Beach Resort and Bofa Beach Resort. The township has a population of 122, 899 according to Kenya census (2009). HIV/AIDS prevalence at Kilifi county stands at 7% according to KAIS (2012).The communities living here include Mijikenda, Swahili, Bajuni, Indians, Arabs, Europeans as well as other native Kenyan communities who migrated during colonial times. This town council was chosen because it presents a semi-rural urban set up in the coastal region which has the highest prevalence of MSM in Kenya. Data from DHIS (2014) shows presence of self-identified MSM who are 300 in total.

3.4 Study Population

Kilifi town council has 300 self-identified homosexuals. For the purpose of this research, Men who have sex with men in Kilifi town council and have self-identified themselves and those who are not self-identified were the target population. This included all MSM above 18years, all ethnicities and socio economic background. Both kings and queens were included. The study population also involved a law enforcement officer, one MSM representative, an NGO officer, CASCO and nurse working in a gay friendly facility.

3.5 Sampling Techniques.

This study utilized non probability sampling. The sampling used was snow balling sampling or chain referral sampling method due to the special nature of the study population. The initial subjects were sought at MSM friendly health services and MSM self-identified groups. After observing the initial subject, the researcher asked for a referral from the subject to help identify people with a similar trait of interest.

3.6 Sample Size Determination.

The sample size should be adequate to generate statistically significant results that can be compared or contrasted with other findings (Castillo, 2009). According to literature review, the population under study is special in the fact that they engage in unlawful activities under the Kenyan constitution, hence no study has clearly shown the exact data of existing MSM in Kenya though their existence is unquestionable looking at the available limited data (Sharma& Bukasi, 2008). Time, financial resources, and human capital in data collection are some of the factors that affect the desirable and manageable sample size. With these considerations, the researcher sampled all available and consenting homosexuals until there was be no new data in 3 subsequent respondents. Total of 72 MSM were reached through questionnaires.

3.7 Pilot Study and Pretesting

The study questionnaire, focused discussion guide and key informant structured interviews were pretested in Mtwapa town council. Ten MSM and two key informants were used. Pilot study results helped in eliminating bias and errors in data collection tools.

3.8 Validity

Validity is the accuracy and credibility of the data in terms of how this data aligns with the reality. Internal and external validity should be ensured by the researchers (Creswell, 2009). Threats to internal validity affect the confidence in concluding that there is a relationship between the dependent and independent variables (Morgan and Gliner, 2009). In this case, maturation could be a threat to internal validity (Krauth, 2011) but the groups mature at the same rate. The internal validity can also be affected by measurement of the dependent variable (Jackson, 2008). If the measurement of the dependent variables is not perfect, then the extreme scores would move towards the mean (Jackson, 2008). This threat was addressed by cross-examining the measurement of the dependent variables. Selection is another threat to internal validity (Krauth 2011). This involves the method of selecting the samples from the study. This threat was addressed by adopting a snow balling sampling technique where chain referral was used. Experimental mortality is another threat to internal validity (Morgan and Gliner, 2009). This happens when some of the participants drop out of the experiment or fail to make it through the entire study (Krauth, 2011). This threat was minimized by maintaining anonymity of the study subjects. The study was however affected by this threat since respondents could drop out of the study by choice.

External validity is the extent to which the result of the study can be generalized across settings, individuals, and times (Morgan and Gliner, 2009). Threats to external validity can take the form

of population validity and ecological validity (Krauth, 2011). In terms of population validity, the sample included in the study was representative enough of the whole population, on top of that, the findings apply to MSM across selected age groups.

3.9 Reliability

Reliability is the degree to which an assessment tool produces stable and consistent results. In this study, reliability of the study instruments was ensured through pre testing the tool to ensure errors and biases are eliminated.

3.10 Data Collection Techniques

This study utilized both primary and secondary data to investigate the outlined objectives. The primary data was collected by self-administered open and closed structured questionnaires given to MSM, two focused group discussion with 12 MSM each and structured key informant interviews with key people who included a health worker at Kilifi District hospital, CASCO (County Aids and STI control officer), non-Governmental Organization officer, MSM representative and law enforcer. The researcher also utilized research assistants who were trained in data collection. Data from FGD and key informant interviews were audio recorded. Secondary data was from the related literature.

3.11 Data Analysis

Data from questionnaires was cleaned. Data cleaning is the process of determining incomplete, unreasonable, or inaccurate data followed by enhancing the quality of the dataset by correcting the omissions and errors (Chapman, 2005). The process includes completeness checks, limit checks, format checks, reasonableness checks and going over the data to establish any inconsistency such as outliers and tests for normality. It also entails validation checks for

compliance against set codes of ethics and standards that apply when handling data such as privacy.

Data cleaning began by specifying the errors, searching for the errors, error correction, and finally re-documentation. In line with the recommendations of specifying type of errors, the researcher looked to establish spelling of variable names, invalid characters, out of range values (outliers), missing variables, and incorrect values. When establishing incorrect values it entails checking for transposition of key values, typographical errors and data entered in the incorrect place. This entailed correcting fields with more than one variable for example age and gender. Data was then analyzed numerically in percentages. Baseline demographic statuses like income, age religion were analyzed. The researcher utilized descriptive statistics to verify for any inconsistency by keenly checking the minimum, maximum, sum, and frequencies for the variables. Further the measures of central tendency such as the mean, standard deviation were used in the process. Study used Statistical package for social scientists (SPSS) version 21.0 to analyze data. In case of any missing data, the researcher would re- enter the data. Chi square and F test were the statistical methods used to establish relationship between selected variables.

3.11.1 Thematic content Analysis

Thematic analysis is a form of categorizing strategy for qualitative data. In this study, thematic analysis offers accessible and theoretically-flexible approach to analyzing qualitative data. The study used quotes reflecting themes emerging from objective thematic analysis. Thematic analysis was used to analyze the focused group discussion and key informant interview audios. Emerging themes were guided by the study objectives and research questions. The researcher then integrated the qualitative and quantitative data to answer the study questions.

3.12 Logistical and Ethical Considerations

3.12.1 Research Ethics Committee Approval

In this study, permission was requested from the relevant authorities to collect primary data. Before data collection, ethical approval was obtained from Kenyatta University Research Ethics Committee (appendix xii) and the Ministry of Education, Science and Technology and National Commission for Science and Technology (NACOSTI) (appendix xiii). The Kilifi county commissioner consent was sought to conduct study in Kilifi town council (appendix xiv) and Medical officer in-charge Kilifi District hospital. The study also adopted and upheld the non-plagiarism policy by ensuring that any content drawn from other studies was well acknowledged through proper in-text citations and proper references. The researcher maintained objectivity in reporting the findings of the study without biasness.

3.12.2 Consent for the Questionnaire, Focus Group Discussions and key informant interviews

Before data collection, participants were informed that the study was voluntary and they had a right to refuse to participate or discontinue at any time with no negative consequences. Before administration of the questionnaire, informed consent was obtained from each research participant, who then signed a consent form as an indication of agreement to participate in the study (See Appendix I). Confidentiality of the respondents was maintained by ensuring the use of codes and not names on the questionnaire. On completion of the questionnaire the data collected was kept under a lockable cabinet throughout the duration of data collection and was only to be accessible to concerned people in the research team. The participants put the forms in an unmarked envelop and seal it before dropping it in a box. With regards to FGDs, verbal

consent was obtained from all group members and only one consent form was signed by the FGD moderator to signify the group's acceptance to participate in the study (See Appendix III). To maintain confidentiality during the discussions, emphasis was made that what was said during the discussions would stay within the group. A respectful approach in an open climate was used in order to obtain valid data. Open questions were posed in order to make the informants feel comfortable. Verbal consent was sought before the Key informants were interviewed and the duration of the interviews and FGDs was 45 minutes to 1 hour each. Permission was sought from the focused group discussions participants and key informants to have the discussions tape recorded. The tapes recorded were kept under lock and key in a cabinet during data collection and were only accessible to research team during transcribing.

3.12.3 Community considerations in the study

Studies that focus on community problems (eg, drug abuse, human immunodeficiency virus infection, teen pregnancy, youth violence etc) run the risk of stigmatizing such communities or inadvertently reinforcing common misconceptions about such communities within the dominant culture. Aspects of informed consent were considered in socially recognizable community and the concept of beneficence, that is, of doing no harm while maximizing potential benefits was applied. There were no direct benefits to the community. Research participants were considered as partners, not research subjects.

This study used its findings to assist community organizations in the designing and implementing of interventions in improving sexual and reproductive well-being of the already existing MSM and development of community education and involvement to prevent crop up of new ones

CHAPTER FOUR: RESULTS

PRESENTATION, ANALYSIS OF DATA AND INTERPRETATION OF FINDINGS

4.0. Introduction

This chapter presents the questionnaire return rate, demographic characteristics, data analysis and interpretation. The data presented includes: the practice of homosexuality and its related health risks in Kilifi town council, Kilifi county, Kenya.

4.1. Questionnaire Response Return Rate

The study obtained 72 filled-in and returned questionnaires.

4.2 Demographic Information

Data on table 4.1 indicates demographic information of the respondents. Majority of the respondents were aged between 21-30 years (72.2%). Majority (72.2%) of the respondents indicated that they were homosexual and (27.8%) were bisexual. On marital status of the respondents (63.9%) indicated they were single, (27%) of the respondents were married and (8.3%) divorced. On age when they were attracted to same sex individuals, (80.6%) of respondents revealed that they started being attracted to other men when they were between 11-20 years. On level of education attained, (38.9%) had attained tertiary education, (31.9%) primary school and 21(29.2%) secondary school. The findings also indicated that majority 38(52.8%) of respondents earn less than 10,000 Kenya shillings per month. 24(33.3) indicated they earn between Ksh. 11,000-40,000 and 10 (13.9%) were earning Ksh. 41,000-90,000. Ma28 On religion, (38.9%) of the respondents were Muslim, Christian Roman Catholic 18 (25.0%), (19.4%) were Christian protestant and 12 (16.7%) were atheists

Table 4. 1 Socio Demographic Information

AGE OF THE RESPONDENTS	FREQUENCY	PERCENTAGE	Mean
18-20 years	4	5.6	24Years, SD=0.676
21-30 years	52	72.2	
31-40years	14	19.4	
51-60 years	2	2.8	
Sexual Orientation			
Homosexual	52	72.2	
Bisexual	20	27.8	
Marital Status			
Married	20	27.8	
Single	46	63.9	
Divorced	6	8.3	
Age in which the Respondents were attracted to other men			
1-10 years	12	16.7	17years, =SD=0.481
11-20 years	58	80.6	
21-30	2	2.8	
Level of Education			
Some primary education	0	0	
Primary	23	31.9	
Secondary	21	29.2	
tertiary education	28	38.9	
Average income of the respondents			
<10,000 ksh	38	52.8	Ksh.7,000,SD=0.723
11,000-40,000	24	33.3	
41,000-80,000	10	13.9	
RELIGION			
Christian roman catholic	18	25.0	
Christian protestant	14	19.4	
Muslim	28	38.9	
Atheist	12	16.7	

4.3 predisposing factors to Homosexuality

Table 4.2 shows various factors that predispose men to homosexuality. Results indicate that 62(88.9%) of the respondents chose homosexuality as a Lifestyle, while 8(11.1%) stated it is not a Lifestyle. Lifestyle means it is something you do deliberately as a way of life.

Homosexuality; inborn or choice 48(66.7%) of the respondents indicated that sexual preference is choice, 24(33.3%) of the respondents stated that sexual preference is inborn.

Reasons for homosexual preference as choice (N=48). Twenty eight respondents (58.3%) chose to have same sex orientation because of peer pressure, 8(16.7%) of the respondents indicated that they chose to have same sex orientation because naturally they are attracted to men, 10(20.8%) chose to have same sex orientation because they don't find women attractive sexually and no one forced them. Finally, 2(4.2%) had other reasons like prison environment exposure. The findings showed that most respondents chose homosexuality as a result of peer pressure. These findings are depicted by various statements from MSM in Kilifi... ” *some of them are satisfied with living that way that is it is inborn. Peer pressure is however a major contributing factor*” (FGD MSM, Kilifi town council, Kilifi subcounty) ..” *I was wooed into homosexuality in high school by my friends in a boy's boarding school....”* *When I went to prison, they forced me to have sex with them, with time I liked it, there was no option*” (FGD MSM Kilifi town council, Kilifi subcounty)

Introduction to homosexuality; majority, 50(69.4%) of the respondents indicated that they were introduced by their friends, 6(8.3%) of the respondents were introduced by one of their relatives, 2(2.8%) by a domestic worker, 14(19.5%) by other people.

Presence of other homosexual family members (N=12); about 4(33.3%) of the respondents indicated that their brother is gay, 2(16.7%) cousin, 6(50.0%) had a gay uncle.

Table 4.2 Predisposing factors to homosexuality

	Frequency	Percentage
Whether Feeling on Sex Orientation is a Lifestyle		
Yes	64	88.9
No	8	11.1
whether sexual preference is inborn or choice		
Inborn	24	33.3
Choice	48	66.7
Reasons why the respondents chose to have same sex orientation (N=48)		
Naturally attracted to men	8	16.7
Peer pressure	28	58.3
Idon't find women attractive sexually	10	20.8
Others	2	4.2
Who introduced the respondents to this sexual orientation		
My friend	50	69.4
A relative	6	8.3
A domestic worker	2	2.8
Others	14	19.5
Whether the respondents had any other family member who was a gay		
Yes	12	16.7
No	60	83.3
Other Person in Respondents family who is a Gay (N=12)		
Bother	4	33.3
Cousin	2	16.7
Uncle	6	50.0
Others	0	0.00

4.3.1 Upbringing and Homosexuality

Table 4.3 below shows upbringing and its association with homosexuality. More than three quarters 54(75%) of the respondents believed that upbringing had nothing to do with sexual orientation gay activities while 18(25%) believed so. The FGD members felt that upbringing

somewhat had a role to play in a boy child becoming a homosexual depending on the family setup as noted by these MSM statements... ” *At times you are in a family where all the other children are girls except you. When they go for example for sex work or with boyfriends and you are young, and you see everyone being carried around, and may be the men they are with are big, sometimes they pull you in and tell you to try it*”(23 year old MSM FGD MSM Kilifi town council, Kilifi subcounty). *“Bad relationships in a family...for example you have grown in an environment where the family mistreats you until you feel that you are not at the right position. So you just feel, let me just try that thing that I feel is fine for me to do.”* (FGD MSM, Kilifi town council, Kilifi subcounty).

Family type one was raised in and homosexuality; more than half 38(52.8%) of the respondents had single parent family-mother, while 6(8.3%) single parent –father, 20(27.8%) both mother and father present and 6(8.3%) were raised by a guardian or others. These findings are further echoed by CASCO...”. *Being brought up in a single mother parent’s family can influence one’s being an MSM because of the desire to explore various things that they see happen to their sisters and mothers. Lack of freedom among children in a family, they are not sharing with anyone, and that can make them to end up being gay”* (CASCO, Kilifi county). Also the FGD further depicts single mothers over pampering as one of the reasons a boy may grow up to be a homosexual as stated by a 26 year old MSM *“Mothers pampering....and if the mother brings men into the house, the mother is careless, she is having sex openly and she is enjoying it loudly and it disturbs you. The next day you would want to call your fellow age mate, and tell him about what was done to your mother previous day and request him to try it with you. And that is how it starts..”* (FGD MSM Kilifi town council, Kilifi subcounty).

Sexual abuse during childhood and homosexuality; about 52(72.2%) of the respondents indicated that they did not experience any sort of sexual abuse while 20(27.8%) had experienced sexual abuse. These findings are further ascertained by MSM representative...” *Sexual abuse at an early age can somehow lead them to be MSM because one might be abused while he is young but after that some boys will hate homosexuality but others enjoy it when they are young and grow up with it...*” (Kilifi MSM representative, Kilifi town council). These findings are further confirmed by one 25 year old MSM..” *like my friend, his uncle influenced him into being gay*

because he would have sex with him since his childhood. He has been in that environment for long, at first he saw it as a bad thing but later he liked it..” (25 year MSM,FGD MSM, Kilifi town council, Kilifi subcounty).

Pornography when growing up and becoming a homosexual; majority 50(69.4%) of the respondents indicated that they were watching gay pornography when growing up while 22(30.6%) had never. These findings revealed that most of the respondents had watched pornography FGD...*”watching pornography when young and in adolescent, both gay and other pornography gives one an impression that its enjoyable to have sex with men..”* (FGD, Kilifi town council).

Bullying and violence against boy child and influence on sexual orientation; majority 42(58.3%) of the respondents indicated that they had never experienced bullying or violence during schooling period, while 30(41.7%) had experienced either bullying or violence at one time. The FGD findings somewhat show that a considerable number of boys, though not majority had bad experiences of violence with men when growing up... *”bullying by men is not a major contributing factor during school years but sometimes when one is bullied by boys they may tend to think they are a weaker sex and enjoy company of girls more, so when he grows up will look up to men like protectors and will want that protection feeling hence end up as the “queen” in a homosexual relationship..”* (FGD MSM, Kilifi town council, Kilifi subcounty)

Table 4. 3Upbringing and its influence on homosexuality

	Frequency	Percentage
Believing that upbringing had anything to do with sexual orientation		
Yes	18	25.0
No	54	75.0
Types of family setup		
Single parent family-mother	38	52.8
Single parent –father	6	8.3
Both mother and father present	20	27.8
Raised by guardian or others	8	11.1
Experience any sort of sexual abuse in childhood		
Yes	20	27.8
No	52	72.2
watching of pornography growing up		
Yes	50	69.4
No	22	30.6
Experience any bullying or violence during school		
Yes	30	41.7
No	42	58.3

4.4 Role played by respondents in homosexual relationship

Table 4.4 presents information on role played by respondents. Forty two 42(58.3%) of the respondents indicated that they played a king role while 30(41.7%) played a queen role.

Table 4. 4 Role played by respondents in a homosexual relationship

Role played	Frequency	Percent
King	42	58.3
Queen	30	41.7
Total	72	100.0

4.5 Respondents' awareness of their HIV status

Table 4.5 presents information on Respondents HIV status. Results indicate that 56(77.8%) of the respondents knew their HIV status while 16(22.2%) do not know their HIV status.

Table 4. 5 knowledge of respondents HIV status

Know status	Frequency	Percent
Yes	56	77.8
No	16	22.2
Total	72	100.0

4.6 Last HIV test

Fig 4.1 shows that 58% of respondents had a HIV test more than 3 months ago and 42% of respondents had a test less than 3 months ago.

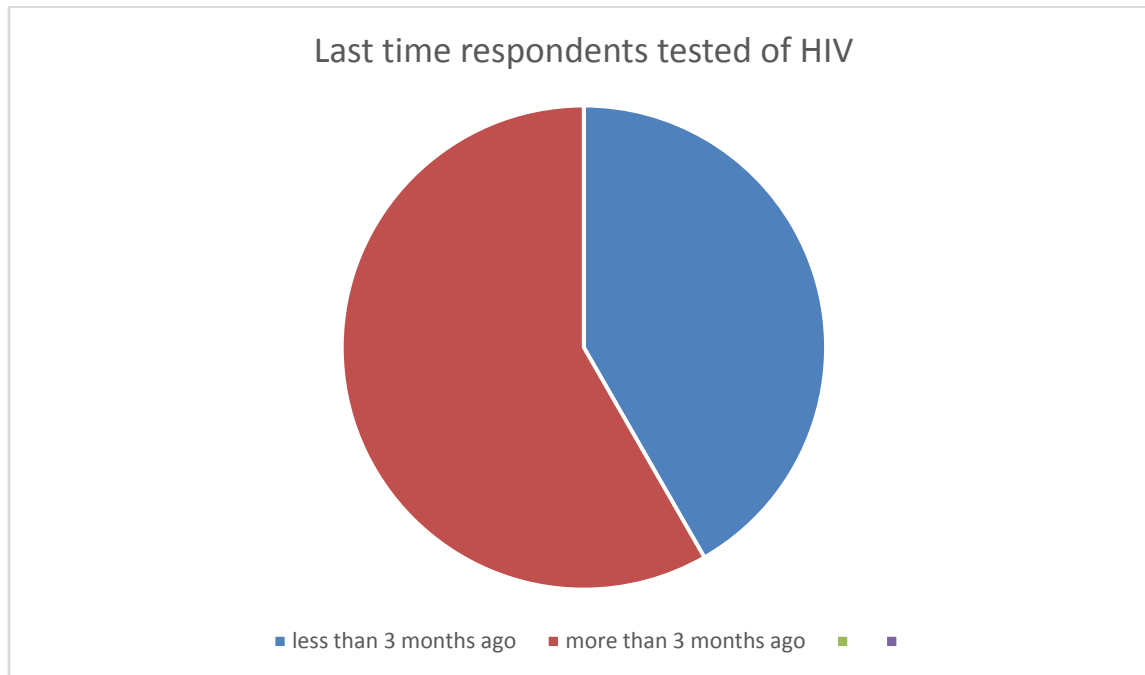


Figure 4. 1When last HIV test was done

4.7 HIV testing with sexual partners together

Table 4.6 presents information on HIV testing with their sexual partners together. Results indicate that 48(66.7%) of the respondents don't go for HIV testing with their sexual partners together while 24(33.3%) do so.

Table 4. 6Testing of HIV with sexual partner.

Test with partner	Frequency	Percent
yes	24	33.3
no	48	66.7
Total	72	100.0

4.8 Having more than one sexual partner concurrently over the last one year

Table 4.7 presents information on respondents on whether they had more than one sexual partner concurrently over the last one year. Results indicate that 60(83.3%) of the respondents had more than one sexual partner concurrently over the last one year while 12(16.7%) do have one sex partner.

Table 4. 7 more than one sexual partner concurrently over the last one year

Multiple sexual partners	Frequency	Percent
yes	60	83.3
no	12	16.7
Total	72	100.0

4.9 Number of sexual partners

Figure 4.2 shows respondents number of sexual partners, 22 (30.6%) have One sexual partner, two partners 18(25.0%), three partners 14(19.4%), four partners 4(5.6%), five partners 6(8.3%) and not applicable 8(11.1%). The findings revealed that most respondents had multiple partners.

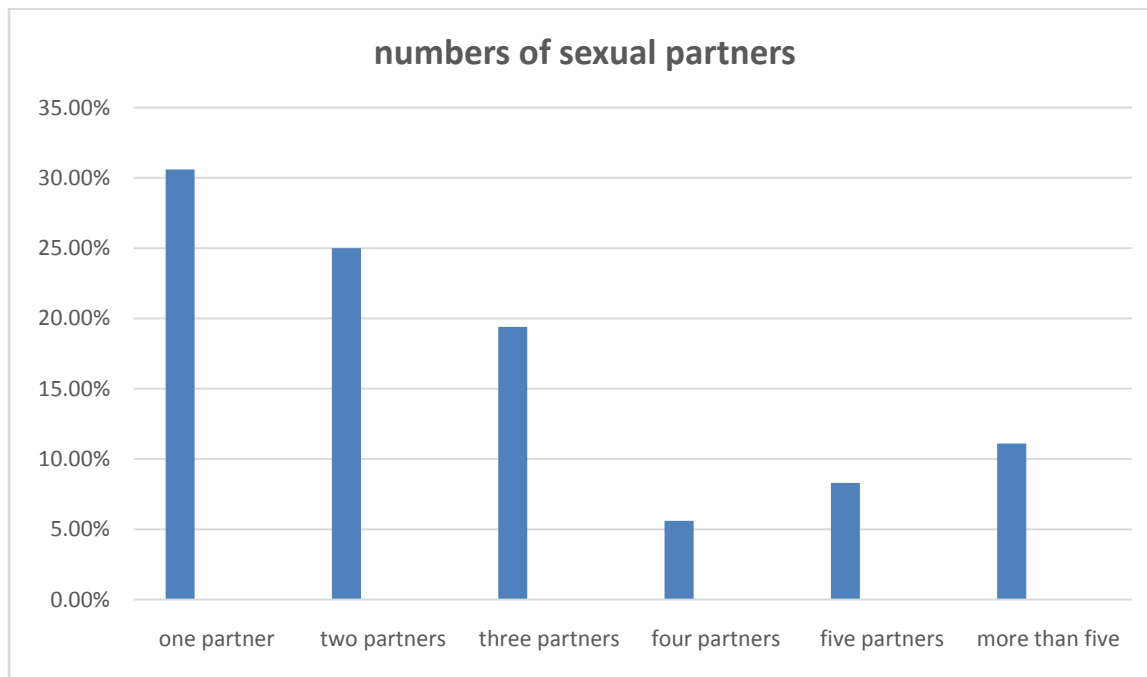


Figure 4.2 Number of sexual partners

4.10 Use of condom by the respondents

Table 4.8 shows that 22 (30.6%) of homosexuals use condom for every sexual encounter, 42 (58.3%) use condom sometimes, meaning other times they don't use condom during sexual intercourse while 8 (11.1%) never use condom at all. This being a key population exposed to HIV/AIDs and STI due to the sexual activity, this condom use is still very low as stated in the FGD..” *Sometimes you find a mam and you feel like doing sex without any protection, you don't want to use a condom or anything because you want it without a condom*”.(FGD MSM, Kilifi town council, Kilifi subcounty).

Table 4. 8 Condom use by respondents

Condom use	Frequency	Percent
all the time	22	30.6
sometimes	42	58.3
never	8	11.1
Total	72	100.0

4.11 Reasons why there is no use of condoms all the time or sometimes

Table 4.9 shows reasons as to why respondents do not use of condom all the time, results indicate that 34(47.2%) of the respondents were under influence of drugs or alcohol, 20(27.8%) do have one mutual partner who they trust and 18(25%) respondents indicated condom reduce pleasure. These findings were echoed in FGD..” *At times you go into a hide out and you look at a guy’s penis and you like it but you have no condoms, no lubricants, you have sex without protection, you use saliva so long as it gets inside you*”.(FGD MSM,Kilifi town council, Kilifi subcounty).

“..you may meet with some guy and maybe we had not planned to meet, he has no condom, I have no condom, he has no lubricant I too do not have lubricant, and there is that need, if you leave him there is no day you shall meet, so you use saliva to have him lubricated and penetrate, ---emergency.....you cannot leave that.. .”(FGD MSM,Kilifi town council, Kilifi subcounty).

” *Too much use of drugs like substance abuse and alcohol and group sex is common among us where condoms are rarely used*” (FGD MSM, kilifi town council, Kilifi subcounty)

Table 4. 9 reasons why respondents don't use condom all the time

Reason for not using condom	Frequency	Percent
have one mutual partner who we trust	20	27.8
was under influence of drugs or alcohol	34	47.2
condom reduce pleasure	18	25.0
Total	72	100.0

4.12 Use lubricants all the time when having sexual intercourse

Table 4.10 Presents information on whether respondents use lubricants all the time. Results indicate that 44(61.1%) of the respondents use lubricants all the time while 28(38.9%) do not.

Table 4. 10 Use of lubricants

Use of lubricants	Frequency	Percent
Yes	44	61.1
No	28	38.9
Total	72	100.0

4.13 Uses of alcohol and other drugs

Figure 4.3 shows use of alcohol and other drugs. Results indicate that 34(47.2%) of respondents use alcohol, Intravenous drugs 4 (5.6%), marijuana 16 (22.2%), Alcohol & bhang 12 (16.7%) and those who don't use any drug 6 (8.3).

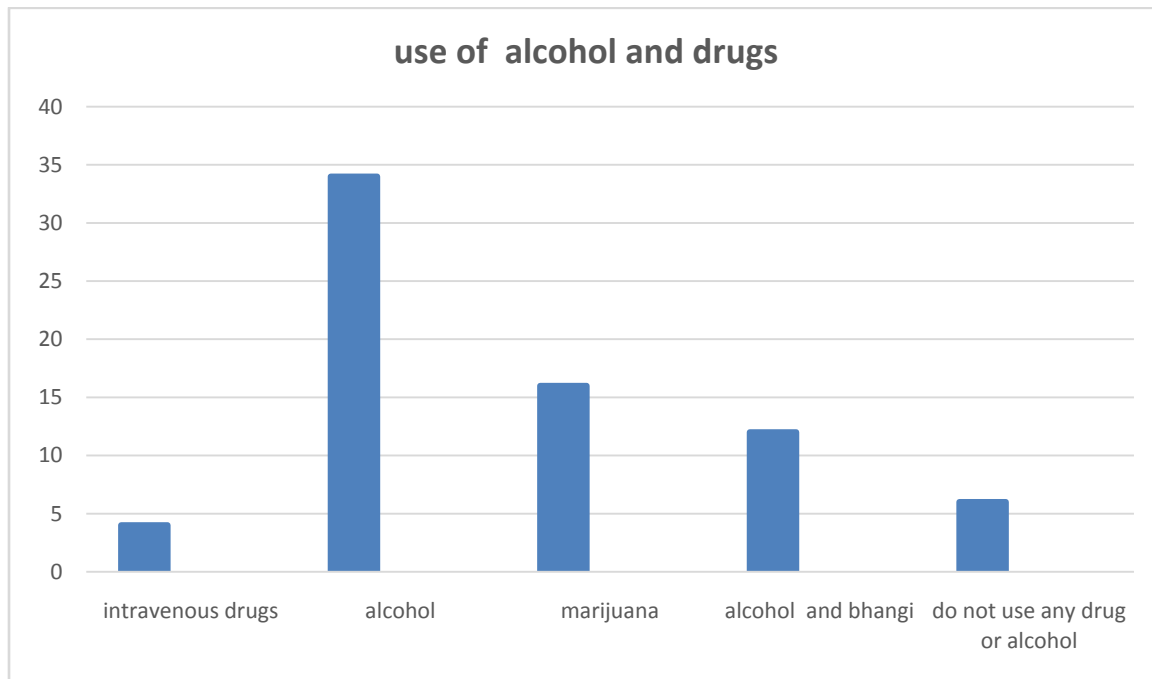


Figure 4.2 Use of alcohol and drugs

4.14 Suffering from any disease

Table 4.11 shows whether respondents had suffered from any disease. Results indicate that 32(44.4%) of the respondents have suffered an STI, 22(30.6%) HIV/AIDS, 6(8.3%) suffer hemorrhoids 4(5.6%) suffer anal fissures and 8(11.1%) suffered STI, AIDS and fissures. These findings conclude that the respondents had one type of infection or multiple infections with STI and HIV/AIDS being the burden infections. these findings were confirmed in FGD..” *At times you know your HIV status and you meet with a person and you look at him and decide this one is whole and I would give him without a condom only to realize he is HIV positive and not on ARVs, it is much better the one that is on ARVs....Being gay alone increases your chances of being infected with HIV*” (FGD, Kilifi town council, Kilifi subcounty).

Table 4. 11 Diseases respondents have suffered from

Infection suffered	Frequency	Percent
HIV/AIDS	22	30.6
Hemorrhoids	6	8.3
STI	32	44.4
anal fissures	4	5.6
more than one	8	11.1
Total	72	100.0

4.15 Existing Health Promotion and Management Services for Homosexuals

Fig 4.4 presents information on access of health services. Results indicate that most of respondents at 58(80.6%) access government health facility services, 12(16.7%) access both government and private hospitals. The FGD discussions showed that all MSM do seek health services either from private or public health facility with government health services having more clients. These findings are confirmed as stated....” *We go to KEMRI for free STI screening and treatment, picking lubricants and condoms –prevention package, for HIV testing.*” (FGD MSM Kilifi town council, Kilifi subcounty).

“*..we go to Kilifi County Hospital to a particular nurse in CCC that always treats us immediately without allowing you to wait in the queue. Others think you have gone to snatch them their husbands...Mnarani dispensary we also get health services*”..(FGD MSM, KILifi town council, Kilifi subcounty).

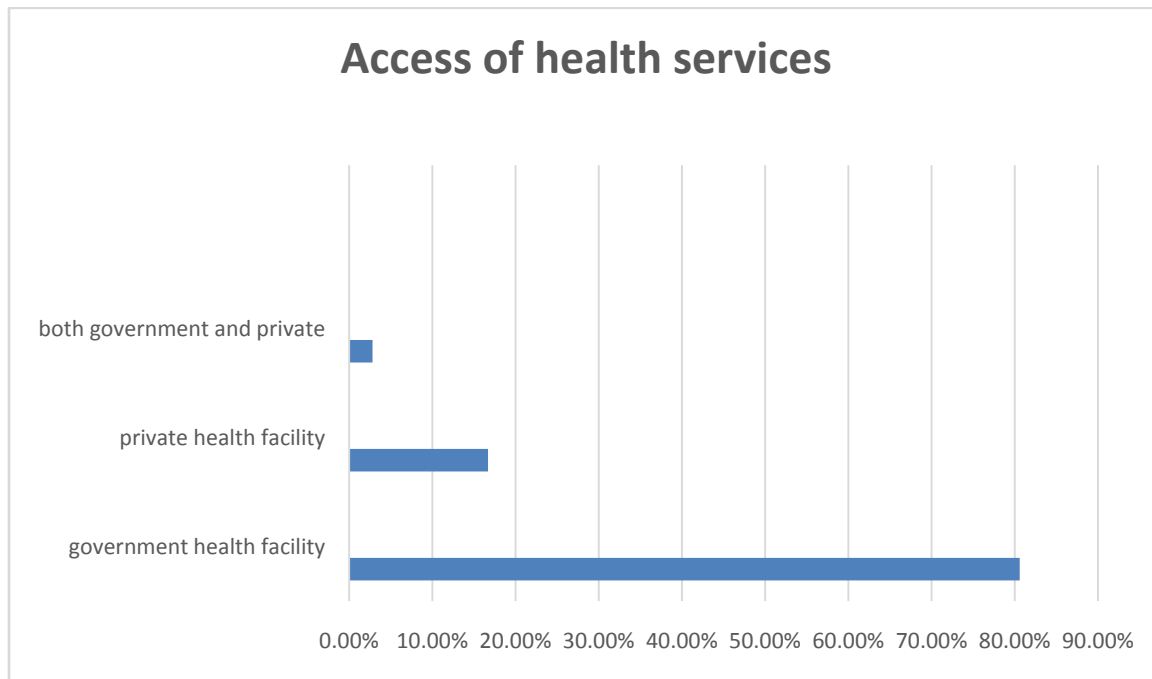


Figure 4.3 Access to health services

4.16 Disclosing sexual orientation to health service providers

Table 4.12 presents information on disclosing sexual orientation to service providers. Results indicate that thirty eight respondents 38(52%) do disclose their sexual orientation to health service providers while 34(47.2%) do not. These findings show that most homosexuals fail to disclose their sexual orientation to service providers. These findings are further confirmed by the gay friendly nurse...*”they don’t disclose their sexual orientation unless they find someone who understands them”*(GAY friendly nurse, KDH, Kilifi subcounty) and CASCO reaffirms..*” Yes they do to those people they are comfortable with. It depends on the health care provider attending to them. If one is open to them they usually disclose. However, if one is judgmental and shows a negative attitude to them they usually shy away and cannot disclose at all..”* (CASCO, KILIFI County

Table 4. 12 Disclosing sexual orientation to health service providers

Disclose you are gay	Frequency	Percent
Yes	38	52.8
No	34	47.2
Total	72	100.0

4.17 Whether health service are friendly

Table 4.13 presents the findings on whether health services are gay friendly. Results indicate that 40(55.6%) of the respondents feel that health service are friendly while 32(44.4%) are feel they are not. The findings from the FGD indicated that not all health staffs are gay friendly. This 24 year old MSM stated that..." *Not all staff in KEMRI are friendly...in KDH, some staff are friendly but not all*" (FGD MSM, Kilifi town council)

Table 4. 13 Provision of gay friendly services

Friendly health services	Frequency	Percent
Yes	40	55.6
No	32	44.4
Total	72	100.0

4.18 Discrimination when seeking health care on HIV/AIDS and reproductive health

Table 4.14 shows discrimination while seeking health services. Results indicate that 46,(63.9%) of the respondents are discriminated upon while 26 (36.1%) face no discrimination. These findings are confirmed by FGD where it was a general feeling that discrimination was rampant in health facilities as stated by following statements..." *we face discrimination in and out of hospitals If you are abused you cannot go to report. Many times we report and there is no action*

from police or you go to report and you are chased or locked in yourself unlawfully” (FGD MSM, Kilifi town council, Kilifi subcounty)

” Waiting too long in the queue to be served until other patients start calling us names-angalia shoga, huyo ni shoga ...(FGD MSM, Kilifi town council, Kilifi subcounty). Another MSM notes,*..”some health care providers start preaching to us to stop same sex...Sometimes health care workers whisper or call on each other to come and see “shoga” whenever we go to health facilities for services”* (FGD MSM, Kilifi town council, Kilifi subcounty). The area officer commanding police station ascertains *“..these people are beaten up by people known or unknown to them because of their sexual orientation, mannerisms, clients who refuse to pay after services or failed sex advances”* (OCS, Kilifi).

Table 4. 14 discrimination when seeking health services

Face discrimination	Frequency	Percent
yes	46	63.9
no	26	36.1
Total	72	100.0

4.19 Accessing lubricant and condoms

Table 4.15 presents information on Access of lubricant and condoms. Results indicate that 50(69.4%) of the respondents access lubricants and condoms from government facilities, 15(20.8%) were accessing from NGOs, 4(5.6%) access from chemists, 1(1.4%) accessed from both NGOs and government facilities and 2(2.8%) from others sources. These findings showed that all the respondents do access lubricant and condoms and seek health services either from private or public health facility. This was affirmed by FGD.” ..KEMRI for

free STI screening and treatment, picking lubricants and condoms –prevention package, for HIV testing” (FGD MSM, Kilifi town council, Kilifi Subcounty). The NGO representative from APHIA Plus Nairobi/Coast further emphasizes..” We support the government in providing technical structural dimensions. You know the combination prevention therapy is divided into behavioral and structural. Behavioral is what we are doing with peer education, condom promotion, intervention to gender violence, biomedical is where they are provided with clinical services STI treatment and screening and provision of condoms. Structural is where we are dealing with the community now both the government and relevant institutions.....we are building their capacity...” (NGO Officer, APHIA Plus Kilifi).

Table 4. 15 Accessibility to condoms and lubricants

Attribute	Frequency	Percent
Government facilities	50	69.4
Chemists and pharmacies	4	5.6
NGO	15	20.8
Others	2	2.8
Government and NGOs	1	1.4
Total	72	100.0

4.20 Accessibility to prevention messages

Figure 4.5 shows accessibility to prevention messages. Results indicate that 34 % access health messages from health facility and health groups combined with few accessing from print and social media.

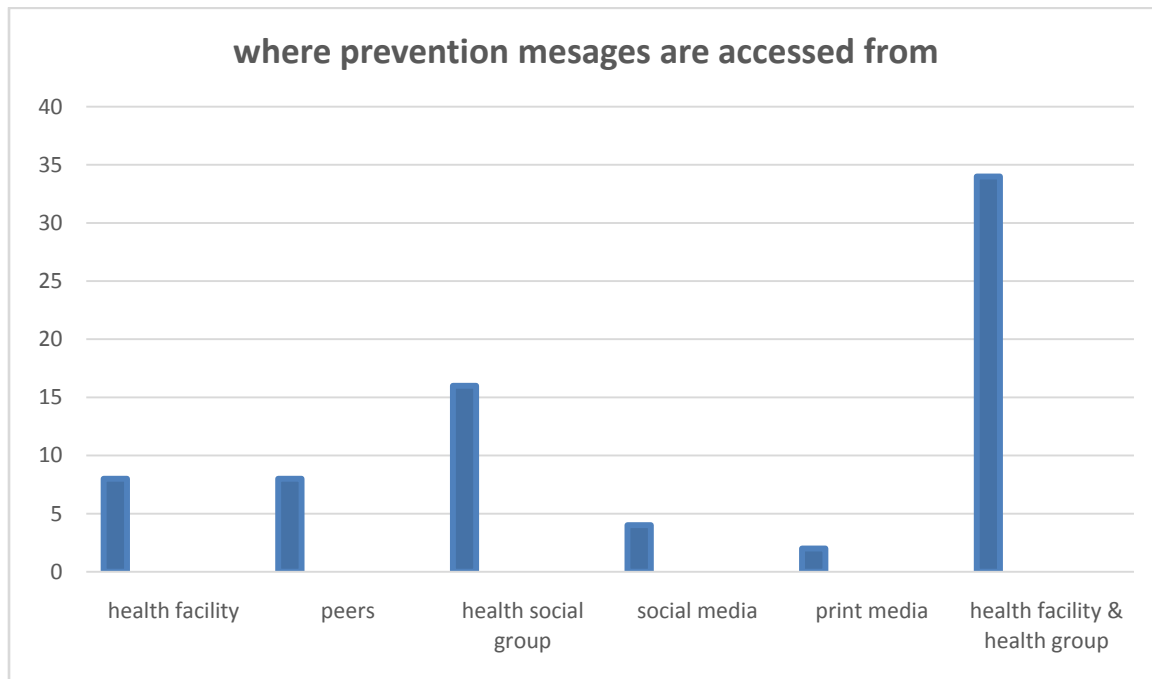


Figure 4.4 Access to prevention messages

4.21 Change of current sexual orientation

Table 4.16 presents information on Change of current sexual orientation. Results show that 54(75%) of the respondents stated that they cannot Change of current sexual orientation while 18(25%) can Change current sexual orientation.

Table 4. 16 change of current sexual orientation

Attribute	Frequency	Percent
yes	18	25.0
no	54	75
Total	72	100.0

4:23 F-test and Chi square

Table 4.17F test

	F-value	df	Significance
watching of phonography growing up choosing to have same sex orientation	103.17	4	0.002
watching of pornography when growing up accessing lubricant and condoms	26.25	4	0.004
number of sexual partners suffering from various diseases	122.33	2	0.000
other person of the family have any other family member who is a gay	202.11	2	0.002

Results: From the top row of the table above, F-statistic, $F=103.17$, $df = 2$ and $P = 0.002$, ($P > 0.001$ $P < 0.005$). **Conclusion:** watching of phonography growing up has some relationship with choosing to have same sex orientation ($p < 0.05$).

Results: From the top row of the table above, F-statistic, $F=26.25$, $df = 4$ and $P = 0.004$, ($P > 0.001$ $P < 0.005$). **Conclusion:** watching of pornography when growing up is associated with accessing lubricant and condoms ($p < 0.05$).

Results: From the top row of the table above, F-statistic, $F= 1.22.33$, $df = 2$ and $P = 0.000$, ($P < 0.001$ $P < 0.005$). **Conclusion:** number of sexual partners is related to suffering from various diseases.

Results: From the top row of the table above, F-statistic, $F= 202.11$, $df = 2$ and $P = 0.002$, ($P > 0.001$ $P < 0.005$). **Conclusion:** other person of the family of respondents who is a gay seems to have likelihood that respondents could have any other family member who is a gay ($p < 0.001$).

Table 4. 18 Chi square test

	chi-square	df	Significance
Income	22.200	4	0.000
Education			
Types of family setup			
Introduction of the respondents to sexual orientation	67.467	3	0.000
Types of family setup	22.533	3	0.000
Watching pornography			

Results: From the top row of the table above, Chi-Square statistic, 22.200^a, and $p = 0.000$. Meaning $p < 0.05$ (in fact $p < 0.001$). **Conclusion:** average income of the respondents is related to level of education ($p < 0.001$).

Results: From the top row of the table above, Chi-Square statistic, 67.467^a, and $p = 0.000$. **Conclusion:** type of family setup is associated with Introduction of the respondents to homosexual sexual orientation ($p < 0.001$).

Results: From the top row of the table above, Chi-Square statistic, 22.533^a, and $p = 0.05$. **Conclusion:** type of family setup is related to respondents watching pornography while growing up ($p < 0.05$).

CHAPTER 5: DISCUSSION

5.0 Introduction.

This chapter discusses the findings of the study and relates them to review of literature. Section one provides a discussion on the causes of homosexuality, section two on the health risk factors associated with homosexuality and section three the existing health prevention and management services available for the MSM at Kilifi town council, Kilifi subcounty.

5.1 Causes of Homosexuality

The study has generally showed that homosexuality is a practice one chooses to engage in voluntarily or involuntarily. Homosexuality is an issue of socialization rather than biological, (66.7%) homosexuals are that way as a choice with few believing they were born homosexuals. These findings concurs with those of Ferrebe (2012) in a study done in united states of America, which showed that homosexuality is not inborn or biological as twin studies have failed to prove so. These findings further agree with those of Karanja(2014) in a study done on homosexuality in private boarding schools in Kiambu county Kenya, which concluded that 80% of homosexuals are made and 20% are born. In this study there was very minimal family history of gay in the homosexual individual's family that further strengthens the fact that this behavior is not inborn. Rather this is a sexual orientation one learns or gets socialized into at some point in life, (72.2%)of homosexuals were in the age bracket of 21-30 years, with most having realized their sexual orientation at mean age 17 years SD 0.481 years. Furthermore, (88.9%) of the MSM said homosexuality is a lifestyle, meaning it is a learned behavior. These findings of homosexuality as a choice agree with those of Robert Goetz in 2004, in a study done in United States

which concluded that homosexuality is a choice. Making a choice is a decision in the mind that too often originates in the heart from feelings. However, laws and moral standards are not set in place based on feeling or emotions. From this study, homosexuality stands out as a matter of nurture rather than nature.

Child upbringing has a lot to do with individual turning out to be homosexual in the future, (52.8%) of the respondents were raised by single mothers. From FGD results most single mothers unknowingly pampered the boy too much or sisters who over feminized the boy child and never allowed them to assume masculine roles or engaged in sexual activities with different opposite sex members and the growing boy child grew to assume feminine characters. These findings tally with those of James (2006) in his study in United States on upbringing and homosexuality, which indicated that females who include mothers, sisters and the extended female family members, teachers, baby sitters and others can wound a boy when he is growing up in a variety of ways. Females often overwhelm the growing boy with too much smothering attention and love. They may overprotect him, leaving him feeling incapable and emasculated. The boy may grow up being criticized by females for his weaknesses, causing lasting feelings of shame, self-doubt and insecurity. These findings further concur with those of Hezborn, Bernard, Elizabeth and Wilfridah (2012) in a study done in Kenya on perception of students on homosexuality in secondary schools, (17.8%) believed socialization process in family led to homosexuality. Feminization and family constellations had a role in some being homosexuals as affirmed by the FGD where most MSM noted that cruel mothers who mistreated fathers may lead a boy growing with dislike for girls. These findings concur with a study done by Bayne and Parsons in 2005 on role of upbringing in homosexuality, where they stated that constellation in childhood and poor

mother/ father relationships can lead men to become oppositional in their relationships and tend to push women away or reject them. They have feelings of dislike, resentment, disgust or even hatred towards women. Some MSM are completely conscious and blatant about their dislike for females. Karanja (2014) also concluded that parent/child relationship when growing up contributes to (60%) of homosexuality.

Men who have sex with men (69.4%) watched pornography when growing up and this had a role in their homosexual orientation, these findings agree with those of Bailey (2005) in his study on role of sexual conditioning to homosexuality, he stated that In the highly sexualized context of pornography, boys may confuse feelings of curiosity, envy, awe and wonder with sexual arousal. Once learned, pleasurable sexual behaviors are reinforced and boys continue engaging in them. When a boy becomes sexually aroused by male images out of sexual exposure, it may cause him to believe or confirm to him that he is homosexual or gay. This then becomes learned part of his identity. The FGD MSM also agreed that watching gay pornography in teenage years gave them feelings of pleasure and an assumption that male sex was better than female sex.

Sexual abuse when growing up is another cause of homosexuality, where the boy was abused by a male or sodomised at a young age, (27.8 %) of the MSM were abused when growing up, those abused physically through bullying by boys in early years were (41.7%), these findings concur with those of Bern (2005) in his study in United states on bad experiences of boy child with men when growing up and its role in homosexuality, these experiences may be abuse (physical or sexual), harassment, rejection or non-inclusion. Boys who develop needy relationships with males long for male intimacy, long to be taken care of by males and they become dependent of

male attention, affection and approval. Karanja (2014) in her study done in Kenya, found out that sexual abuse contributes to 20% of a boy child becoming a homosexual later in life.

Peer pressure (58.3%) stands out as one of the leading causes of homosexuality with majority (69.4%) of the respondents being introduced to this behavior by friends in adolescent years or few cases in imprisonment. The FGD further notes that peer pressure is the leading cause of homosexuality, with most men having been introduced to it by peers during teenage years. These findings concur with those of Ferrebe 2012 who suggested that homosexual orientation develops as a result of psychological and environmental influences and experiences when the boy is growing up. Peer pressure is one factor that happens in the course of growing up. These findings further concur with those of Karanja (2014) in a study done in Kenya that listed peer pressure (60%) as one of the leading causes of homosexuality.

However this study has failed to prove that religion has a role to play in one being a homosexual where atheists are believed to be majority in the homosexuality. In this study, only 16.7% of respondents were atheists and Pearson's correlation failed to show any relationship between the two. This therefore differs with the findings of Berin 2007 on his study in the United States on whether religion affects sexual orientation where he concluded that most homosexuals are atheists. The discrepancy however may be as a result of environmental set up, where in Coast region Islamic is the dominant religion.

Tourism and commercial sex were linked to causing homosexuality to a little extent as affirmed by the FGD and MSM representative. They noted that tourism contributes to commercial sex with white men as a means of making a livelihood.

5.2 Health Risks among Homosexuals

Homosexuals are among the key populations that are exposed to more health risks as a result of the nature of “un natural” sex acts they engage in, they also face social and physical health risks because they engage in illegal sexual activities that are punishable under the Kenyan Law. Homosexuals who knew their HIV status were 77.8% but 58% had a test more than three months ago. This makes these findings inconclusive since these people are exposed to more risk of contracting HIV with each sexual encounter. Furthermore,(66.7%) have not been tested with their partners. From the study, majority of the homosexuals suffer or have suffered from STI’s, HIV/AIDS at (44.4%) and (30.6%) respectively. These findings coincide with those of Kenya Aids Indicator survey 2013 which showed incidence of HIV/AIDs to be greatest among homosexuals at 35%, meaning HIV/AIDs is a burden to them. STI’s make an individual more susceptible to contracting HIV/AIDs; furthermore, most of the gay people who know their current HIV status had a test more than 3 months ago, therefore it cannot be said conclusively that this is the actual number of those infected, since every sexual activity is a risk. The fact that majority of them have multiple sexual partners or have had multiple sexual partners at (83.3%) further puts them at more risk, this echoes findings of Valle et al (2004) in a study done in Australia, who reported that MSM have 1.3 times the number of sexual partners compared to heterosexual men. In other words, MSM compared to their exclusively heterosexual partners have more opportunities to engage in risky sexual behaviors due to their greater number of sexual partners.

Bisexuality among this group is at (27.8%), this means that these are married men, probably with families, married to women, yet they have same sex partners secretly. This puts these men together with their partners at more risk for HIV/AIDS and other STI's.

Non condom use (69.4%) puts MSM at more health risks for STI's and HIV/AIDS. These findings concur with those of Valle et al (2004) who noted that No sexual behavior is more risky than unprotected anal sex, and evidence indicates that percentages of MSM who engage in this behavior remain high. Furthermore, another reason for non-condom use as cited in the FGD was commercial sex, where male sex workers get more money from clients not willing to use condoms and influence of alcohol and substances. One of the major reasons noted for non-condom use is the influence of drug and alcohol at (47.2%) out of (69.4%) who use condoms inconsistently or not at all, this concurs with a study done by Steuve, O'Donnell, Duran, Doval and Geier (2002), in a study conducted in over 3,000 MSM discovered that nearly one third of their sample "reported being high on drugs or alcohol the last time they had sex with a non-main partner, and men who were high were over 60 percent likely to have engaged in unprotected receptive anal intercourse. Substance abuse was associated with other factors, including having multiple sexual partners, trading sex and succumbing to peer norms discouraging condom use that increase risk of MSM contracting HIV. The findings further concur with those of Scott and Stanley (2008) in a study done in Mombasa on factors associated with self-reported unprotected anal sex among male sex workers where most male sex workers stated influence of drugs and highly paid sex as a leading causes for non-condom use.

Most of the homosexuals at (81.7%) abuse substances and other drugs. These findings support those of wheeler 2005 in a study done in United Kingdom on relationship between drug abuse

and risky sexual behavior, he stated that Situational evidence demonstrates that concurrency of sexual behavior and substance use predicts risky sexual behavior.

5.3 Existing Health Promotion and Management Services for Homosexuals

Most of the homosexuals (58%) access health care services from government facilities at. The facilities that provide gay friendly services are few though, with Kilifi county Hospital taking the lead. USAID funded NGO's like APHIA Plus and Kemri support the government to provide comprehensive care to homosexuals, capacity building of staff and provision of lubricants and condoms to the MSM. The CASCO interview revealed that the few health facilities offering gay friendly services are not known to all MSM. The health care workers have been trained on gay friendly services but updates are not done or follow up on the same. The Gay friendly nurse at KDH further echoed those concerns. Local NGO's. CBO's and KEMRI are other places where MSM access health services and supplies like lubricants, condoms and comprehensive care for MSM who are HIV positive.

On Discrimination when seeking health services, there was somewhat some level of discrimination at 63.9%, this means that discrimination is still there to an unacceptable level. It was noted from Gay friendly nurse at KDH that although training has been done on gay friendly services, most health care workers attitude towards homosexuals has not changed. They need to take them as clients and detach from their own personal,moral and religious values when offering care to this group as CASCO reaffirmed.

The CASCO and Gay friendly nurse at KDH noted that health services at the government facilities are free of charge and they are accessible to MSM, the challenge is that some supplies like lubricants are not available all the time and necessary resources like capacity building of

health care workers on MSM reproductive health. Availability of equipment for anal health services is also a real challenge.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

From this study, it can be concluded that homosexuality is not in born rather it's as a result of socialization process as opposed to biologic causative factors. Among the major causes of homosexuality in Kilifi town council, Kilifisub county is peer pressure, choice- where one deliberately makes conscious decision to be homosexual, upbringing of the boy child where the environmental factors cause them to assume this homosexuality orientation from adolescence. Upbringing issues like over domineering and over pampering single mothers can lead to homosexuality later in life. Sexual abuse by a male adult, watching pornography while growing up, especially homosexual pornography, abuse during early developmental years by members of the same sex are some of the causes of homosexuality. Friends and prison environment are some of the factors that introduced these men to homosexuality.

Health risks among these people are, HIV/AIDs, STI's, anal fissures and anal incontinence. The inconsistency in condom use and non-condom use puts them at even more risk, drug and substance abuse has a role also in non-condom use, sex for pay also is a health risk. Social risks include discrimination and stigma in the community and the health facilities. In community they experience violence and unlawful arrests.

Bisexuality among these people is not common though it's there which puts them at more risk for major health consequences.

Health services that are existing are accessible and free but not efficient since some resources lack, like proper capacity building on gay friendly services, equipment for anal treatment and all time supply of lubricants.

6.2 Recommendations

6.2.1 Recommendations to the Ministry of health

1. Policy planning and implementation on homosexual friendly sexual and reproductive health services, even though homosexuality is illegal in Kenya, gay people should not be denied health care as a basic human right because they are affected by adverse health outcomes due to nature of their sexual activities.
2. There is need to scale up capacity building on gay friendly services, refresher follow up trainings for existing trained health care workers on gay friendly services and subsequent follow-up on the same by the county and subcounty health teams.
3. The Kilifi subcounty health services team need to scale up on the number of health services offering comprehensive gay friendly services in the Kilifi subcounty
4. Consistency in provision of supplies by County health team, drugs and equipment for provision of sexual and reproductive health services to homosexuals with emphasis on reproductive health education especially prevention of risky sexual behaviors.

6.2.2 Recommendations to families and communities

1. Parental roles and responsibilities should be emphasized. Parents should be involved in their children's life more to know what they are going through and what they are up to. The parental role should be extended even up to school, both boarding and public schools and should not be left solely on the teachers.
2. For the families with single mothers, they should avoid over pampering the boy child, involve him in masculine activities and have trustworthy male role models for these boys.
3. The community should be made to understand that stigma is not a healthy habit to the development of a society; no one should be discriminated on basis of sex, sexual orientation, religion or race.

6.3 Future Research

For the purposes of future research, this study has identified that most of the homosexuals have more than one sexual partner at one given time, and few of them are commercial sex workers, research should be done to establish who the clients of these people are in a bid to fight the HIV/AIDS pandemic.

Homosexuality is still a debate that takes place in "low tones" in our African setup; this is because it's an African behavior as per peoples perception, un natural and illegal. Research needs to be done on the effects of discrimination and stigma on homosexuals towards their general physical and mental well-being.

REFERENCES

Adam B, Sears D., & McMillan S, (2002). Accounting for unsafe sex: interviews with men who have sex with men. *Journal of sex research*. 37,24-36.

Association of Nurses, (2003). Changing Hostile Attitudes Toward Homosexuals in a Region Facing One of the Highest Incidences of HIV/AIDS. *Journal of the Association of Nurses in AIDS Care*, 14(1), 86.

Bailey, J. Michael, PhD, and Zucker, Kenneth, PhD. (2005). Childhood Sex-Typed Behavior and Sexual Orientation: A Conceptual Analysis. *Developmental Psychology*, vol. 31, No. 1. Obtained from <http://borngay.procon.org/>

Bayne and Parsons (2005), *Human Sexual Orientation. The Biologic Theories Reappraised*.pp 236.

Bily, C. A. (2009). *Homosexuality: opposing viewpoints*. Detroit: Greenhaven Press.

Bem, Daryl, PhD. (2000). "Exotic Becomes Erotic: Interpreting the Biological Correlates of Sexual Orientation. *Archives of Sexual Behavior*, vol. 29, No. 6. Obtained from <http://borngay.procon.org/>

Berin, P. (2007). *Men who have sex with men: social and behavioural research: implications for needs assessment*. London: Health Education Authority.

Bowers, J. R., Branson, C. M., Fletcher, J. B., & Reback, C. J. (2012). Predictors of HIV Sexual Risk Behavior Among Men Who Have Sex with Men, Men Who Have Sex with Men and Women, and Transgender Women. *International Journal of Sexual Health*, 24(4), 290-302

Castillo, J. (2009). Research population. Retrieved May 9th, 2014, from <http://www.experiment-resources.com/research-population.html>

Centre for Disease control and Prevention (CDC), (2010) Most at risk populations, Retrieved May 10th 2014 from <https://www.cdckkenya/marps.html>.

Creswell, J. W. (2009). Research design: Qualitative, quantitative, and mixed methods approach. Thousand Oaks, CA: Sage.

Chapman A., D. (2005). Principles and Methods of Data Cleaning Australian Biodiversity Information Services Retrieved May 9th, 2014, from http://imgbif.gbif.org/CMS_ORC/?doc_id=1262anddownload

Ferrebe, A. (2012). Literature of the 1950s: good, brave causes. Edinburgh: Edinburgh University Press.

Friedman, Richard, MD. (2008). Male Homosexuality: A Contemporary Psychoanalytic Perspective. Yale University Press. Retrieved on May 23rd , 2014 from <http://borngay.procon.org/>

Hezborn, M. N, Bernard, L.,Elizabeth, A and Wilfridah, M. (2012). Perception of students on homosexuality in secondary schools in Kenya. Journal of Biosocial Science, 70(02), 940.

Jackson, S.L. (2008). Research Methods and Statistics. Wadsworth: Belmont

James, W. H. (2006). Two Hypotheses On The Causes Of Male Homosexuality And Paedophilia. Journal of Biosocial Science, 38(06), 745.

Johnson, B., and Christensen, L. B. (2012). *Educational research: Quantitative, qualitative, and mixed approaches*. Thousand Oaks, California: SAGE Publications

Joint United Nations Programme on HIV/AIDS (UNAIDS), (2010): Global report on global AIDS pandemic. WHO Library Cataloguing-in-Publication Data.

Karanja, C. (2014). Factors contributing to prevalence of homosexuality in private boarding secondary schools: a case of kiambu county, kenya. *Journal of Public Med*, 50(3), 134-140.

Kenya AIDS indicator Survey (KAIS), (2012): National AIDS Control Council. Nairobi, Kenya.

Kenya National Commission on Human Rights (KNCHR), (2012): Morven Kester E.A. Ltd. Nairobi, Kenya.

Krauth, J. (2011). *Experimental design a handbook and dictionary for medical and behavioral research*. Amsterdam: Elsevier.

Lawrence G, Patrick K, Francis O, Boaz C, Girmay H. (2008): *Kenya modes of transmission study*. Kenya National AIDS Control Council, Kenya.

Locke, K. A. (2005). The Bible On Homosexuality. *Journal of Homosexuality*, 48(2), 125-156.

Maulsby, C. (2012). Differences and Similarities in HIV Testing Among Men Who have Sex with Men and Women (MSMW) and Men Who Have Sex with Men Only (MSMO). *The open AIDS journal*, 6(1), 53-59.

Milton, J. (2010). Mercury causes homosexuality in male ibises. *Nature*, 20, 2.

Morgan, G. A., and Gliner, J. A. (2009). *Research Methods in Applied Settings: An Integrated Approach to Design and Analysis*. Routledge Academic.

Robert E., Charles F., Albert D. and John H (2009). Prevalence of patterns of same- gender sexual contact among men. *Science* 243, issue 4889 PP 342.

Robert T., John H., Edward O. and Gin K (2004). *Sex in America: a definitive survey*. Boston, little Brown and Co. Pp 177-179.

Robert Goetz (2004). *Overcoming Homosexuality*. New York: Macmillan Publishing Co.

Scott, G. and Stanley, L. (2008). Factors associated with self reported unprotected anal sex among male sex workers in Mombasa Kenya. *Journal of sexually transmitted diseases* 35(8), 745-752.

Sharma A, Bukusi E, Gorbach P, Cohen CR, Muga C, Kwena Z, et al. Sexual identity and risk of HIV/STI among men who have sex with men in Nairobi. *Sex Transm Dis* 2008; 35(4):352-354.

Steuve. A., O'Donnell, L., Duran, R., & Geier, J. (2002). Being high and taking sexual risks: findings from multisite survey of Men who have sex with men. *AIDS education and prevention journal*. 14 Pp 482- 495.

Wheeler, D. P. (2005). Working With Positive Men: HIV Prevention With Black Men Who Have Sex With Men. *AIDS Education and Prevention*, 17: 102-115.

Valle, S. D., Evangelista, A. M., Velasco, M. C., Kribs-Zaleta, C. M., & Schmitz, S. H. (2004). Effects of education, vaccination and treatment on HIV transmission in homosexuals with genetic heterogeneity. *Mathematical Biosciences*, 187(2), 111-133

APPENDICES

Appendix 1: Consent Form

This Informed Consent form was administered to MSM in Kilifi town council who participated in the study. The title of the research project is “the practice of homosexuality and it’s related health risks in Kilifi Town Council, Kilifi SubCounty, Kenya”.

Name of researcher: EVAH M MAINA.

Name of Organization: KENYATTA UNIVERSITY

Title of Proposal: the practice of homosexuality and its related health risks in Kilifi Town Council, Kilifi SubCounty, Kenya.

This Informed Consent Form has two parts:

- Information Sheet (to share information about the research with you),
- Certificate of Consent (for signatures if you agree to take part).

You will be given a copy of the full Informed Consent Form

PART I: Information Sheet

Introduction

My name is Evah Maina. I am a post graduate student undertaking a Master’s of Science in Public health- Reproductive Health option, Kenyatta University. As a requirement by the university, for the completion and award of my degree, I am conducting a study on **homosexuality and its related health risks in Kilifi Town Council, Kilifi County, Kenya.** I am going to extensively explain about this research and invite you to voluntarily participate. I am going to give you time to decide on whether you will participate in the research. You are free to consult before making any decision.

I am going to use the language that you understand either spoken or written. You are free to ask any question or clarification about the research during, and after data collection using the contact address provided at the end of this document.

Purpose of the research

Understanding different aspects in the practice of homosexuality and its related health risks among MSM is important in understanding the causes and the consequences of this practice as well as health system capacity in provision of gay friendly services. This information is necessary in identifying gaps towards health care and especially reproductive health needs of homosexuals. This will in turn lead to the necessary policy makers and stakeholders sensitization creation to improve health outcomes to the MSM population.

Benefits

There are no direct benefits for you as an individual but your involvement will help in finding the response to the research question stated in the research proposal. There are no benefits to the community at this stage of the research, but future generations can benefit from the published document. Information obtained from the study will be published.

Risks

There are no risks whatsoever involved in taking part in this research.

Voluntary Participation

Your involvement in this research is completely voluntary. It is your choice whether to take part or not. Whether you choose to take part or not will not affect you in any way. You may change your mind later and discontinue taking part even if you had agreed earlier.

Confidentiality

The identity of those taking part in the research will not be disclosed or shared with anyone. Informed consent will be obtained from you in order to participate in the study. To ensure confidentiality the data collection forms will not bear your name or ethnicity. You will be identified by the study code number. Only the researchers will recognize what your number is and the collected data kept under lock and key. All the data and the information obtained during the study will be used for the sole purpose of meeting the objectives of the study.

Duration

The data collection will only take a period of 35 minutes -1 hour. During this time, you will only be expected to answer the questions asked as outlined.

Contacts

Questions are welcome at the moment or later, even when the study is in progress. If later use the contacts below.

EVAH M MAINA

P.O.BOX 143-10300

KERUGOYA, KENYA.

MOBILE NUMBER 0723 482 308

Email address evahmaina73@gmail.com

Appendix 2: Questionnaire.

This questionnaire is for research purposes. Anonymity will be maintained and the information contained here will be treated with confidentiality. Tick and answer by writing where appropriate.

SOCIO-DEMOGRAPHIC DATA

1. How old are you
2. What is your sexual orientation?
 - a) Homosexual
 - b) Heterosexual
3. Marital status to an opposite sex member?
 - a) Married
 - b) Single
 - c) Separated
 - d) Divorced
4. At what age did you discover you were attracted to men?
- 5) What is your level of education?
 - a) No education
 - b) Some primary education
 - b) Primary education
 - c) Secondary education
 - d) Tertiary education
6. What is your average monthly income?

- a) 10,000 and below
- b) 11,000- 40,000
- c) 41,000- 90,000
- d) 91,000- 130,000
- e) Above 131,000

7. What is your religion?

- a) Christian Roman Catholic
- b) Christian protestant
- c) Muslim
- d) Atheist

8. Do you feel same sex orientation is a lifestyle?

- a) Yes
- b) No
- c) Unsure

9. Do you think your sexual preference is inborn or choice? Explain your answer

- a) Inborn
- b) Choice

Explain your answer above_____

10. If it's a choice, as above:

- i) Why did you choose to have this same sex orientation?
 - a) I am naturally attracted to men
 - b) Peer pressure
 - c) I don't find women attractive sexually

d) Any other, specify_____

ii) Who introduced you to this sexual orientation?

a) My friend

b) A relative

c) A domestic worker

d) Any other, specify_____

iii a) if your answer is “inborn” to question 10 above: is there another member of your family who is gay?

a) Yes

b) No

iii b) if yes above, who?

a) A brother

b) A cousin

c) An uncle

d) Father

11. Do you believe that upbringing had anything to do with your sexual orientation?

a) Yes

b) No

If yes, explain_____

12. What type of family set up were you raised in?

a) Single parent family- mother

b) Single parent- father

c) Both mother and father present

d) Raised by guardian or others

13. Did you experience any sort of sexual abuse as a child?

a) Yes

c) No

14. Did you watch any pornography when growing up?

a) Yes

b) No

15. Did you experience any bullying or violence during school from same sex when growing up?

a) Yes

b) No

16. What role do you play?

a) King

b) Queen

HEALTH RISKY BEHAVIORS AMONG MEN WHO HAVE SEX WITH MEN.

1. Do you know your HIV status?

a) Yes

b) No

2. When was the last time you tested for HIV?

a) Less than 3 months ago

b) More than 3 months ago

3. Did you go for testing with your sexual partner?

a) Yes

b) No

4. Have you had more than one sexual partner concurrently over the last one year?

a) Yes

b) No

If yes, how many: a) 2 b) 3 c) 4 d) 5 e) more than 5

5. How would you rate your condom use?

a) Use it all the time

b) Use it sometimes

c) Do not use it at all

6. In the instances when you didn't use a condom, what was the reason?

a) I have one mutual partner who we trust each other

b) I was under the influence of drugs/alcohol

c) Condom reduces pleasure

d) Any other, specify _____

7. Do you use lubricant all the time?

a) Yes

b) No

If no, explain why? _____

8. Do you use any of the following? (Tick where appropriate)

a) Intravenous drugs

b) Alcohol

c) Marijuana

d) Any other (specify)

8. Have you suffered or are suffering from any of these diseases (tick all that apply)

- a) HIV/AIDS
- b) Hemorrhoids'
- c) STI's
- d) Anal fissures
- e) Anal cancer
- f) Anal incontinence

**EXISTING HEALTH PROMOTION AND MANAGEMENT STRATEGIES AMONG
MSM IN HEALTH CARE FACILITIES.**

1. Where do you access health services?

- a) Government health facility
- b) Private health facility
- c) Any other, specify _____

2. Do you disclose your sexual orientation to service providers during a consultation?

- a) Yes
- b) No

If no, explain why? _____

3. Are health services friendly?

- a) Yes
- b) No

4. Do you face discrimination when seeking health care on HIV/AIDS and reproductive health?

a) Yes

b) No

If yes, explain _____

6. Where do you access lubricant and condoms

a) Government clinics

b) Buy from chemists/pharmacies

c) Non-Governmental organizations

d) Any other, specify _____

7. Where do you access prevention messages?

a) Health facility

b) Peers

c) Health social groups

d) Social media

e) Print media

f) Others, specify _____

7. Would you change your current sexual orientation or have you thought of changing it?

a) Yes

b) No

Appendix 3: Focused Discussion Consent Form

Only one consent form for the focus group discussions will be signed by the researcher to show that all the participants have accepted to take part in the study.

Identification of the focused group discussion.....

Number of participants in the FDG.....

Date of the FDG ____/____/____ Place of the FDG_____

Moderator's name_____

Each of the participants has either read the information sheet. I have also explained to the participants the information contained in the information sheet. They have assured me that they fully understand that if they agree to participate in the study, they will have a group discussion of between 6-12 persons which will take 1-2hrs. They understand that they are free to withdraw from the discussion at any time and this will not have any adverse effects. They also understand that the discussion will be tape recorded.

The participants have agreed to take part in the study.

Name of the researcher_____

Signature_____ Date_____

Appendix 4: Focused Group Discussion Guide.

1. What causes same sex attraction?
2. How does a boy child upbringing affect their sexual preference in adulthood?
3. How does the family type affect sex preference in adulthood?
4. What is the average age that one discovers they are attracted to members of same sex?
5. What are signs of same sex attraction?
6. What are some of the risky health behaviors you experience?
7. Where do you access health services, especially HIV/AIDS and reproductive health?
8. How friendly are health service providers?
9. How adequate are the health services currently provided in hospitals?
10. What are the challenges that you face?

Appendix 5: Key informant interviews Consent Form

Only one consent form for each of the key informant interviews. This form will be signed by the researcher to show that each the participant has accepted to take part in the study.

Identification of the Key informant by job title.....

Date of the KII ____/____/____ Place of the KII _____

Interviewers's name _____

Each of the participants has read the information sheet. I have also explained to the participants the information contained in the information sheet. They have assured me that they fully understand and agree to participate in the study. They understand that they are free to withdraw from the interview at any time and this will not have any adverse effects. They also understand that the interview will be tape recorded.

The participants have agreed to take part in the study.

Name of the researcher _____

Signature _____ Date _____

Appendix 6: Key Informant Interviews- CASCO

1. How many health facilities are MSM friendly in Kilifi sub County?
2. What do you think causes homosexuality?
3. Why do you think homosexuality prevalence is high in Kilifi Sub County?
4. How many staffs in Kilifi town council health facilities are trained on provision of MSM friendly services?
5. What are the existing strategies to address MSM health issues in Kilifi Sub County?
6. What are the existing NGO's collaborating with government on working with MSM?
7. Do MSM disclose their sexual orientation to service providers? Explain your answers
8. What do you think are the barriers to MSM accessing HIV/AIDS prevention and care in Kilifi sub County?

Appendix 7: Key Informant Interview- KDH Gay Friendly Nurse

1. Have you been trained on Gay friendly services?
2. When was the initial training done?
3. How many updates trainings have you attended?
4. How many of you have been trained on Gay friendly services at KDH?
5. How does discrimination affect MSM health seeking behaviors from KDH?
6. How accessible and affordable are health services to MSM at KDH?
7. What training have you received on MSM health care?
8. Have you been trained on handling of anal treatment like use of proctoscopy, anal antibiotics? Explain your answer.

Appendix 8: Key Informant Interview- MSM Representative

1. What do you think causes same sex attraction?
2. How many self identified MSM do you have in your support group?
3. How many of these are married to members of opposite sex?
4. How many are commercial sex workers?
5. Who are their clients?
6. How does tourism affect MSM and commercial sex?
7. How comfortable do you feel when accessing health services in health facilities?
8. Where do MSM prefer to access medical services?
9. Where do MSM access condoms and lubricants from? Are they enough?
10. What do you think should be done to improve MSM health outcomes?

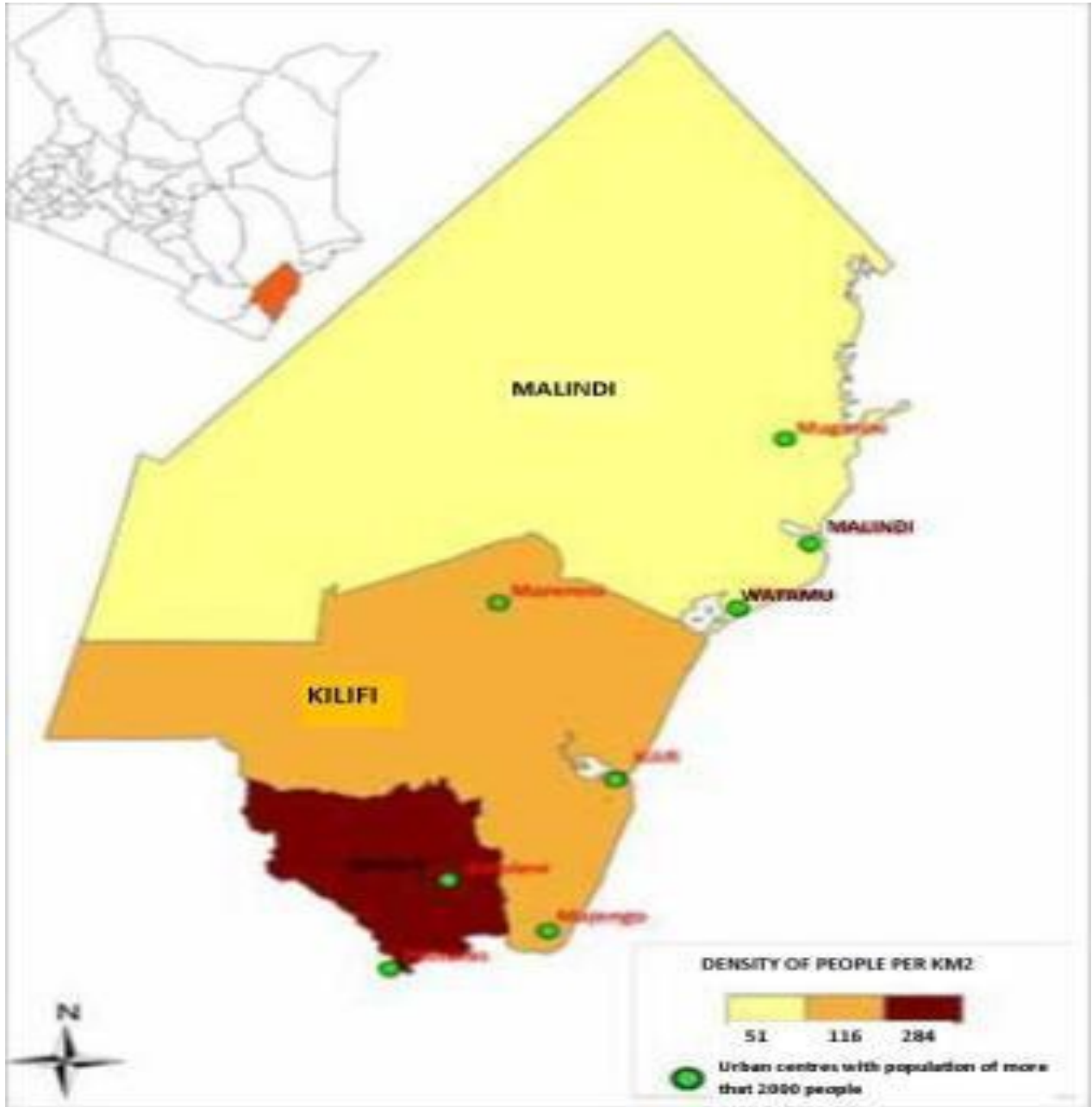
Appendix 9: Key Informant Interview- NGO Officer

1. Which NGO do you represent?
2. Why did you feel the need to have an MSM support group in Kilifi?
3. How many MSM in Kilifi town council does your NGO support?
4. How do you support the government in MSM services programming?
5. Do you think what the government and NGO are doing to provide health services is enough?
6. If Not, what more needs to be done?
7. What do you think causes discrimination of MSM at health facilities?
8. Why is prevalence of MSM high in Kilifi?
9. What are some of the factors that expose MSM in Kilifi to HIV/AIDS?

Appendix 10: Key Informant Interview- Law Enforcer

1. What do you think causes high prevalence of MSM in Kilifi town?
2. How do you handle cases of sexual violence against homosexuals? Who are the main perpetrators?
3. How does community react to homosexuals?
4. What happens when you arrest a homosexual in commercial sex?
5. How does tourism influence homosexuality in Kilifi?
6. What is the government doing to curb sexual violence and physical violence among MSM?

Appendix 11: Map of Kilifi County



Appendix 12: Kenyatta University Ethics Committee Approval



KENYATTA UNIVERSITY
ETHICS REVIEW COMMITTEE

Email: chairman.kuerc@ku.ac.ke
secretary.kuerc@ku.ac.ke
ercku2008@gmail.com
Website: www.ku.ac.ke

P. O. Box 43844 - 00100 Nairobi
Tel: 8710901/12
Fax: 8711242/8711575

Our Ref: KU/R/COMM/51/521

Date: 19th August, 2015

Evah Mumbi Maina
Kenyatta University,
P.O Box 43844, Nairobi

Dear Mumbi

RE APPLICATION NUMBER PKU/372/I 345- "THE PRACTICE OF HOMOSEXUALITY AND ITS RELATED HEALTH RISKS IN KILIFI TOWN COUNCIL, KILIFI SUBCOUNTY, KENYA- VERSION 2

1. IDENTIFICATION OF PROTOCOL

The application before the committee is with a research topic "The practice of Homosexuality and its related health risks in Kilifi Town Council, Kilifi Sub county, Kenya" - Version 2 dated 18th August, 2015.

2. APPLICANT

Evah Mumbi Maina, Department of Environmental Health

3. STUDY SITE

Kilifi Town Council, Kilifi Sub County, Kenya.

4. DECISION


The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines AND APPROVED that the research may proceed for a period of ONE year from 19th August, 2015.

5. ADVICE/CONDITIONS

- i. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
- ii. Serious and unexpected adverse events related to the conduct of the study are reported to this board immediately they occur.
- iii. Notify the Kenyatta University Ethics Committee of any amendments to the protocol.
- iv. Submit an electronic copy of the protocol to KUERC.

When replying, kindly quote the application number above.

If you accept the decision reached and advice and conditions given please sign in the space provided below and return to KU-ERC a copy of the letter.


PROF. NICHOLAS K. GIKONYO
CHAIRMAN ETHICS REVIEW COMMITTEE

I, Evah Mumbi Maina accept the advice given and will fulfill the conditions therein.

Signature.....Evah Mumbi Maina..... Dated this day of 25.08.15..... 2015.
cc. Vice-Chancellor

Appendix 13: National commission for Science and Technology Approval



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No. **NACOSTI/P/15/77186/7906**

Date:
3rd November, 2015

Evah Mumbi Maina
Kenyatta University
P.O. Box 43844-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*The practice of homosexuality and its related health risks in Kilifi Town Council, Kilifi Sub County, Kenya,*" I am pleased to inform you that you have been authorized to undertake research in **Kilifi County** for a period ending **1st November, 2016**.

You are advised to report to **the County Commissioner, the County Director of Education and the County Coordinator of Health, Kilifi County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.


SAID HUSSEIN
FOR: DIRECTOR GENERAL/CEO

Copy to:

The County Commissioner
Kilifi County.

The County Director of Education
Kilifi County.



Appendix 14: County Commissioner Kilifi County Approval



THE PRESIDENCY

MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL GOVERNMENT

Telephone: (041)7522103
 Fax: (041) 7522474
 Email kilificc@yahoo.com
 When replying/telephoning
 Quote: EDUC: 12/7 VOL. 1/50

COUNTY COMMISSIONER'S OFFICE
 KILIFI COUNTY
 P. O. BOX 29 - 80108
 KILIFI

And date: 5th February, 2016

Evah Mumbi Maina
 Kenyatta University
 P.O Box 43844 – 00100
 NAIROBI

RE: RESEARCH AUTHORIZATION

The above named is a student at Kenyatta University. She has permission from the National Commissioner for Science Technology and innovations to carry out research on "The practice of homosexuality and its related health risks in Kilifi Town council, Kilifi Sub-County for a period ending 1st November, 2016.

Any assistance accorded to her during her research period will be appreciated.


 A. M. MATIVO
 FOR: COUNTY COMMISSIONER
 KILIFI COUNTY